UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

ZANE M. FLOYD,

Plaintiff,

vs.

CHARLES DANIELS, Director, Nevada Department of Corrections; HAROLD WICKHAM, NDOC Deputy Director of Operations; WILLIAM GITTERE, Warden, Ely State Prison; WILLIAM REUBART, Associate Warden at Ely State Prison; DAVID DRUMMOND, Associate Warden at Ely State Prison; IHSAN AZZAM, Chief Medical Officer of the State of Nevada; DR. MICHAEL MINEV, NDOC Director of Medical Care, DR. DAVID GREEN, NDOC Director of Mental Health,

Defendants.

Case No. 3:21-cv-00176-RFB-CLB

Las Vegas, Nevada
Thursday, December 16, 2021
10:28 a.m.

EVIDENTIARY HEARING, DAY 6
AM SESSION

CERTIFIED COPY

REPORTER'S TRANSCRIPT OF PROCEEDINGS

THE HONORABLE RICHARD F. BOULWARE, II,
UNITED STATES DISTRICT JUDGE

APPEARANCES: See next page

COURT REPORTER: Patricia L. Ganci, RMR, CRR
United States District Court
333 Las Vegas Boulevard South, Room 1334
Las Vegas, Nevada 89101

Proceedings reported by machine shorthand, transcript produced by computer-aided transcription.

APPEARANCES:

For the Plaintiff:

DAVID S. ANTHONY, ESQ.
BRAD LEVENSON, ESQ.
OFFICE OF THE FEDERAL PUBLIC DEFENDER
411 E. Bonneville Avenue, Suite 250
Las Vegas, Nevada 89101
(702) 388-6577

For Nevada Department of Correction Defendants:

D. RANDALL GILMER, ESQ.
OFFICE OF ATTORNEY GENERAL
555 E. Washington Street, Suite 2600
Las Vegas, Nevada 89101
(702) 486-3427

DOUGLAS RANDS, ESQ.
OFFICE OF ATTORNEY GENERAL
100 N. Carson Street
Carson City, Nevada 89701
(775) 684-1259

For Defendant Ihsan Azzam:

NADIA AHMED, ESQ.
SKLAR WILLIAMS, PLLC
410 S. Rampart Boulevard, Suite 350
Las Vegas, Nevada 89145
(702) 360-6000

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LAS VEGAS, NEVADA; THURSDAY, DECEMBER 16, 2021; 10:28 A.M.

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P R O C E E D I N G S

THE COURT: Please be seated.

Go ahead, Blanca.

COURTROOM ADMINISTRATOR: Now calling -- now calling Zane M. Floyd versus Charles Daniels, et al., Case Number 3:21-cv-00176-RFB-CLB. This is the time for evidentiary hearing, Day 6.

Starting with counsel for plaintiff, please note your appearance for the record.

MR. ANTHONY: Good morning, Your Honor. David Anthony from the Federal Public Defender's Office for Zane Floyd. Also appearing with me is my cocounsel, Brad Levenson, and appearing by video link from the Nevada Department of Corrections is Zane Floyd.

THE COURT: Good morning.

MR. GILMER: Good morning, Your Honor. Randall Gilmer on behalf of the NDOC Defendants in this case, which for purpose -- ease of the record is all defendants that are currently in the case other than Dr. Azzam. To my right is Senior Deputy Attorney General, Doug Rands, also of the Office of Attorney General also representing the same defendants. Immediately to his right is Director Charles Daniels, defendant in this case. And on the bench behind me is Natasha Petty,

legal researcher, Office of Attorney General, as well as Deputy Director Warden Gittere, listed as Warden Gittere, is a defendant in this case. Good morning.

THE COURT: Good morning.

MS. AHMED: Good morning, Your Honor. Nadia Ahmed appearing on behalf of Dr. Azzam who's with me and present in the courtroom. Good morning.

THE COURT: Good morning. So what's our order of witnesses today?

MR. ANTHONY: Your Honor, my understanding is that we'll be hearing from Dr. Azzam this morning. And then after that, Dr. Petersohn.

THE COURT: Okay. So as it relates to the motion to compel, Ms. Ahmed, I assume that Mr. Pomerantz shared with you the contents of our, sort of, ex parte discussion about the testimony. What I'm going to do at this point is defer. I want to hear from Dr. Azzam, hear the nature of the questions that are being asked. And then I will rule as it relates to the motion to compel, specifically, the aspect of the consult part of the communication with Director Daniels, specifically.

But I think that the doctor has other relevant testimony, so we can start there. But I just wanted to make sure, Ms. Ahmed, you were at aware or at least had an opportunity to speak with Mr. Pomerantz about our colloquy yesterday.

MS. AHMED: That is correct, Your Honor. Thank you.

THE COURT: Okay. All right.

Anything else we need to do before we start with Dr. Azzam?

MR. ANTHONY: Not from plaintiff, Your Honor.

THE COURT: Okay.

MR. GILMER: Your Honor?

THE COURT: All right. Dr. Azzam, if you want to come up and take the stand, please?

Before you take your seat, we need to swear you in, Doctor.

COURTROOM ADMINISTRATOR: Please, raise your right hand.

IHSAN AZZAM, M.D., having duly been sworn, was examined and testified as follows:

THE COURT: All right. You can take a seat, Doctor.

If you are comfortable with, you can -- you can take your mask off. You're behind the Plexiglas. But you're not required to do so.

THE WITNESS: Thank you.

THE COURT: Okay. Could you state and spell your full name for the record. And the microphone, Doctor, is actually that little bar that's in front of you, so that's where you speak. But don't put your hands on it or shuffle papers on top of it because, otherwise, my court reporter may have a few

choice words to say to you.

THE WITNESS: My name is Ihsan Azzam, I-H-S-A-N. The last name is A-Z-Z-A-M, as in Mary.

THE COURT: Thank you.

THE WITNESS: Thank you.

THE COURT: Mr. Anthony -- or Mr. Levenson.

MR. LEVENSON: Thank you.

DIRECT EXAMINATION OF IHSAN AZZAM, M.D., Ph.D.

BY MR. LEVENSON:

Q. Good morning, Dr. Azzam.

A. Good morning.

Q. What is your title?

A. I'm the Chief Medical Officer for the State of Nevada.

Q. And as CMO, do you work for the Nevada Department of Health and Human Services?

A. Yes, sir.

Q. When did you become the CMO for the State of Nevada?

A. On May 21st, 2018.

Q. And I assume you are a doctor.

A. Yes, sir.

Q. And how long have you been a doctor?

A. Since 1982.

Q. And as CMO, can you tell us, generally, what your responsibilities are?

A. Sure. I provide guidance and recommendations for statewide

public health programs. I provide advice and technical assistance for the community providers and clinics, local health authorities, regulatory boards like the Board of Medical Examiners, Board of Pharmacy, Board of Dentists. I provide advice to community coalitions and task forces.

(Court reporter clarification.)

THE WITNESS: Advice and consultation guidelines for disease prevention, health education, early detection of disease and control, general public policy, provide lectures at the University of Nevada in Las Vegas and Reno. I am the liaison of the State of Nevada with the Federal Government, the Centers for Disease Control and Prevention, FDA, and other organizations like the ASTHO, which is the Association of State and Territorial Health Officials.

What's the -- this is what I do. Develop reports, create guidelines for -- for preventing events, emerging diseases like COVID or other emerging infections.

BY MR. LEVENSON:

Q. What is your role with regard to COVID in the State of Nevada?

MR. GILMER: Objection, Your Honor. Relevance.

THE COURT: How -- overruled. I think it's highly relevant.

MR. GILMER: Okay.

THE WITNESS: When COVID emerged, our role was to

prepare the community for a virus or a pandemic which is going to reach our nation and our state. So we decided to implement the mask based on CDC recommendation and recommended for Nevada residents to be able to telecommute and work from their homes, handwashing, environmental hygiene, and individual hygiene, social distancing. And later on we recommended the vaccine for every eligible person. And, eventually, my role is to evaluate the occurrence of this disease, the burden, the medical burden, the societal burden, how many new cases we have every day, how many positive tests, what is the test positivity rate, is it increasing, is it decreasing. The metrics for evaluating how we are doing with this never-ending pandemic, where we have to evaluate how many hospitalized individuals and, as you know, hospitalization is related to the severity of infection, and how many individuals die, are they vaccinated, are they not vaccinated, something like that.

THE COURT: Dr. Azzam, I just want to go back very quickly. How did you become the Chief Medical Officer?

THE WITNESS: I applied for the position and ...

THE COURT: So describe the process and what you went through.

THE WITNESS: Originally, I worked as the state epidemiologist up until, I think, 2015. Then I became the state medical epidemiologist, which is dealing mostly with, like, medical part and generating guidelines for controlling and

preventing disease, up until 2018.

During my period as the state epidemiologist and state medical epidemiologist, I acted as a chief medical officer because several times we didn't really have a chief medical officer. So I acted, frequently, as a chief medical officer, and when Dr. John DiMuro, who was the Chief Medical Officer before me moved on, I applied for the position and I got interviewed and got selected.

THE COURT: Okay. And you were interviewed and selected by whom?

THE WITNESS: By the Director of Health and by the Director of Health and Human Services and by the administrator of the Health Division and the Bureau Chief for Community Health and the program manager for the public health preparedness.

THE COURT: And what are the qualifications that are generally required for someone to be the Chief Medical Officer of the State of Nevada?

THE WITNESS: You have to have a medical degree with a doctoral degree and experience in public health.

THE COURT: I'm sorry, you said you have to have a medical degree and a Ph.D.?

THE WITNESS: Yes. Actually, it's -- there are three qualifications.

THE COURT: Okay.

THE WITNESS: One is you have to be a physician who is

licensed with public health experience. The other one is you have to have -- you have to be a physician who is going to be licensed with public health experience. And the third one is you to have to be a physician with a terminal degree like Ph.D. And I qualified under the last category.

THE COURT: Okay. So can you tell me what degrees you actually have and in what fields.

THE WITNESS: I have a medical degree from the University of Cluj-Napoca from Romania, and I got that degree in 1982. I completed my residency in obstetrics and gynecology in 1986. And I completed my Master's in Public Health in 2002 from the University of Nevada Reno and my Ph.D. in Environmental Health and Toxicology in 2010 from the University of Nevada Reno.

THE COURT: Okay. Thank you.

THE WITNESS: No problem.

THE COURT: Go ahead, Mr. Levenson.

BY MR. LEVENSON:

Q. Dr. Azzam, you were talking about your graduate certification in public health. Does -- can you tell us a little bit about that.

A. Yes. CDC requires you as a state epidemiologist to be certified in public health, epidemiology, and biostatistics. So I had to go to the University of Seattle School of Public Health and Community Medicine for 18 months to get a degree called GCP,

which is a Graduate Certificate in Public Health, which is a CDC-sponsored degree. And I got that, I think, in 1996.

Q. And does that cover the discipline of being an epidemiologist or epidemiology?

A. Yeah, it's on epidemiology and biostatistics and demography.

Q. You were talking about your role with COVID in Nevada. Can you state, whatever is public, how Nevada is currently doing with its metrics?

THE COURT: Okay. That, I don't think is relevant, Mr. Levenson. Let's move on from there.

BY MR. LEVENSON:

Q. Have you seen NDOC's 2021 execution protocol?

A. No.

Q. Do you know what drugs are in the protocol?

A. Can you please repeat the question.

Q. Sure. Do you know what drugs are in the protocol?

MR. GILMER: Objection, Your Honor.

MS. AHMED: Objection, Your Honor, relevance. The witness has just said he hasn't seen it.

THE COURT: No, I thought he -- he may still be familiar with the drugs that are in it without having seen it. That's what I thought the question was.

MR. LEVENSON: Correct.

THE COURT: Do you know -- without having seen it, do you know what drugs are in the protocol?

THE WITNESS: I heard about them during a previous hearing when I was in this court. Honestly, I don't remember what they were.

THE COURT: Okay.

BY MR. LEVENSON:

Q. Dr. Azzam, are you aware of a Nevada statute that requires the director of the Nevada Department of Corrections to consult with the Chief Medical Officer regarding the drug or combination of drugs to be used in the execution protocol?

A. Yes, sir.

Q. And what is your understanding of what that statute requires you to do?

MR. GILMER: Objection, Your Honor. Asking for a legal conclusion.

THE COURT: Overruled. I'll allow him to explain what he understands his role to be in the context of the statute.

THE WITNESS: Yeah. I understand that the director of the Department of Corrections need to consult with the Chief medical officer, which was me, regarding the drugs or the drug selected -- no, they need to consult with me, then they select their drugs. So I believe that I provided that consultation -- that he needs to consult with me. I don't need to consult with him.

BY MR. LEVENSON:

Q. Okay. Did you meet with Director Daniels pursuant to the

statute?

A. Yes, sir.

Q. And how many times did you meet with him?

A. Three times.

Q. Do you remember the dates?

A. Yes.

Q. And what are those dates?

A. The first time it was on March 31st, 2021, and the second time it was on April 20th, and the last time it was in May 25.

Q. Before those dates, had you ever met with Director Daniels before?

A. No. Actually, not in person. We talked over the phone, and we had consultation about COVID and about the masks and about isolation and quarantine, but not related to this case.

Q. Okay.

Regarding the March 31st meeting, was that by phone?

A. Yes, sir.

Q. And did Director Daniels tell you what drugs were being considered in the protocol?

MS. AHMED: Your Honor, I would just object. This may be premature as to this question, but with respect to the specifics of the content of the call, consistent with the parties' or at least the defendants' position, we would assert that this is subject to the deliberative process privilege.

THE COURT: Well, here's what we're going to -- the

privilege doesn't cover information. So the question is how do we address the fact that information may have been provided and may have been provided pursuant to the statute in this case. And I will say this to counsel. And this, particularly, applies to Dr. Azzam. I do think the deliberative process privilege is different in this context in which there is a specific statutory role to provide information. There's no doubt about the fact that information is provided. The question is how do we allow for that information to be shared.

I don't think it's appropriate for Dr. Azzam to testify as to what questions he was asked, but the fact is, the information that he provides, and he's already been identified in the statute as providing information, I don't believe is protected by the privilege.

But I do think the privilege protects the back and forth, the colloquy. So if he was asked certain questions by Director Daniels, I think that certainly would be covered. But if he gave an opinion, for example, about fentanyl or ketamine or their use and that was information, that, I think, can be shared because information itself is not protected.

So, Ms. Ahmed, the question is how do we get at that. And I don't think that he can be asked about the questions, but I don't believe that the deliberative process privilege covers information that's communicated.

MS. AHMED: So then, I guess, Your Honor, with respect

to that question, then that is an appropriate objection. But in terms of information that Dr. Azzam himself provided, you will allow that?

THE COURT: Yes. So, in other words, he can talk about his -- his information that he may have shared about drugs or not that he may have provided. He can't say, "Well, these questions were follow-up questions that I was asked. These are particular inquiries that I was asked," or other answers that might give away or disclose what were the inquiries that Director Daniels or other people might have had. But he can say, "My view of fentanyl," if he has one, "is X, Y, and Z. And information was shared." So I think that's not covered by the privilege as it relates to the privilege's carve-out for information itself. But I do think that any questions going to what questions were asked of him would be covered.

MS. AHMED: Understood, Your Honor. Obviously, we've taken a different position in briefing, but we understand -- I understand Your Honor's ruling. And so I would, obviously, defer to the Court on that. So as to this question, I would maintain the objection.

THE COURT: I would sustain it as it relates to that.

MS. AHMED: Thank you, Your Honor.

THE COURT: I mean, the real issue is how do we just get at the information. I don't want us to be going back and forth. I think Dr. Azzam can share his views of the drugs, but

I don't want us to spend 20 minutes trying to get the right question.

So my -- my approach would be simply to ask him, and I could ask him, what is his view of the use of these particular drugs, without getting into what he said to -- or what Director Daniels asked him. And I'll ask counsel's view on that.

Mr. -- Mr. Gilmer?

MR. GILMER: Well, I would just like the record to indicate that we join in full in -- in the objection made by Dr. Azzam's counsel.

Can you repeat your question, Your Honor? I apologize.

THE COURT: So my question is, what information -- so what is his medical opinion as to these drugs and their use in the execution protocol?

MR. GILMER: Yeah, so I think we actually had this conversation at one of the very early hearings in this case, I believe, Your Honor. And I think at that point in time you asked this question. Obviously, Dr. Azzam is a medical doctor -- has medical doctor training and is licensed in different jurisdictions. So I think, as you indicated at that point in time, he has experience to give answers pertaining to that that would not have anything to do with what conversation or what information he may or may not have shared with Director Daniels. So I think your -- what you said is correct. They can ask that question based upon his knowledge as a doctor and these

medications, what his view of them are, and then you don't even have to delve into the communication and conversations he had with Director Daniels.

THE COURT: Well, I'm still going to render an opinion on that, too. So I will tell you, I want to hear what he has to say. I want to hear what the follow-up questions are, and then I am going to address the issue of whether or not he can say, which is the final question, which would be, did you share this information.

But at some point, we have to address that part. But let's start with, I think, the more basic part about whether or not he has a view or not of this medications and what it is.

So, Dr. Azzam, do you have a view of the use of the sequence of fentanyl or alfentanil and then ketamine and then cisatracurium and then I think it's ...

MR. LEVENSON: Potassium acetate.

THE COURT: Potassium acetate as used in the execution protocol in this case?

THE WITNESS: Your Honor, I don't really have experience on how such medication would work for the purpose of execution. My experience with medication that all drugs are designed to cure us from diseases, control diseases, like diabetes and hypertension. Some diseases we cannot cure like diabetes or hypertension, but we can control. Painkillers like fentanyl and opioids are designed to control pain, reduce human

suffering.

There are no studies to tell us how such medication would behave for execution, and I believe that medication -- it depends on from one person to another, how medications will behave. So, honestly, I don't know how medications will be used for the purpose of killing. I only know how medication behave for the purpose of curing and treating and controlling illness.

THE COURT: There you go.

BY MR. LEVENSON:

Q. Dr. Azzam, did you give this information to --

THE COURT: We're not going to get into that yet, so let's move onto the next question.

MR. LEVENSON: Just a moment, Your Honor.

(Plaintiff's counsel conferring.)

BY MR. LEVENSON:

Q. Dr. Azzam, just to clarify. Your opinion that you just gave was for -- for ketamine?

A. For every medication because there is no medication that is designed to kill people.

MR. LEVENSON: So, Your Honor, I was going to move into an area about COVID and the execution, but that would -- those were the only questions I had as to his opinion on the drugs.

THE COURT: So to the extent -- to the extent I allowed COVID questions related to providing an example of how he may have a role in policy in the state. I don't see how this is

relevant to the Court's inquiry here.

MR. LEVENSON: It would be relevant, Your Honor, to effectuate whether it's possible to effectuate or how it's possible to effectuate a safe execution in this environment of COVID. And as a CMO, he's heavily involved in the policy in this state. So his opinion should matter whether this can be done in a safe -- a safe way.

THE COURT: Safe as -- I'm sorry. Safe as to?

MR. LEVENSON: As to -- as to the participants, to the defendant, to anyone who's going to attend the execution, to those working the execution, witnessing the execution, and to -- and to Mr. Floyd.

THE COURT: Yes. Well, first of all, he hasn't seen the execution protocol, so he can't comment on that.

And secondly, again, I don't think that that inquiry is before the Court as it relates to how it would be accomplished, and we don't know all of that information yet. I don't see that that's relevant for the inquiry here or probative.

BY MR. LEVENSON:

Q. Dr. Azzam, have you seen the execution chamber -- have you seen the execution chamber at Ely State Prison?

A. Yes, sir, I did.

Q. And have you seen any of the witness rooms at the -- at Ely?

A. No.

THE COURT: Have you participated in any training

related to the execution?

THE WITNESS: No.

THE COURT: Have you participated in any assistance with preparation of medications related to the execution?

THE WITNESS: No.

BY MR. LEVENSON:

Q. Based on the size of the execution chamber, what would you want to see for COVID safety? What would you want to see people do?

THE COURT: Okay, Mr. Levenson. Maybe I'm not clear about what I was saying about this not being relevant. So if I'm ruling on something and I say it's not relevant, it doesn't mean that we then ask questions which were exactly what I said shouldn't be asked.

MR. LEVENSON: I'm sorry, Your Honor. I thought I didn't -- I had not laid a sufficient foundation for him to comment.

THE COURT: No. I'm saying it's not relevant, is what I'm saying. I don't find that part to be relevant as it relates to this inquiry that's before me. And so if you have a specific question and -- because partly I'm not understanding if you're saying, Mr. Levenson, that somehow you don't think that there are protocols that could be put in place to protect, in this case it's your client's particular interests, obviously, that would be relevant. But I don't think that's an issue that's,

first of all, been put squarely before me as relates to the briefing or the issues here. And I also don't think that it's a relevant line as relates to the case law. So I would move on from there.

MR. LEVENSON: Well, that's the only questions I had. The only other question I had, Your Honor, was whether he had imparted that opinion to Direct Daniels.

THE COURT: Okay. Well, I'll come back to you to see if you have any follow-up questions.

Mr. Gilmer, do you have any questions?

MR. GILMER: I don't have any questions at this point. Perhaps, depending on if Ms. Ahmed does. Thank you.

THE COURT: Ms. Ahmed, do you have any questions?

MS. AHMED: Your Honor, just a couple. Thank you.

CROSS-EXAMINATION OF IHSAN AZZAM, M.D., Ph.D.

BY MS. AHMED:

Q. Dr. Azzam, following on the questions that the Court posed to you, so you have not assisted in any way with the preparation of medication or the training related to the execution, correct?

A. That's correct.

Q. Other than the consultation that you provided to Director Daniels, have you -- without going into the actual consultation itself, have you provided any other consultations to anybody else in relation to the execution?

A. No.

Q. And did you review any drafts or anything related to the execution protocol?

A. No.

Q. Were you in any way involved with the preparation of the execution protocol, aside from those consultations with Director Daniels?

A. No.

MS. AHMED: Thank you, Your Honor. I have nothing else.

THE COURT: Okay. Anyone have any follow-up questions?

MR. GILMER: I have no further questions -- I have no questions.

Thank you for your time, Dr. Azzam.

MR. LEVENSON: Your Honor, we'd like to admit Exhibit 186, which is Dr. -- I'm sorry -- Dr. Azzam's deposition, which is Exhibit 186.

MR. GILMER: Your Honor, I think this is different than -- I think this would go in the same context as we had with Ms. Fox and, you know, not an expert deposition. And so, therefore, it would be an out-of-court statement. As we had conversations -- follow-up conversations with regard to Ms. Fox because she was unavailable, we did reach an agreement to allow certain portions of that to be admitted. I think this is a little different. Dr. Azzam is still here. Obviously, I can have those conversations later, but at this point I would object

to its admission.

THE COURT: I would agree with that.

Mr. Levenson, if you have questions, you can ask questions here. But there's no reason to admit a full deposition. If you want some further testimony, you can go ahead and pursue that. If we want to just proceed directly to this argument about whether or not the consultation should come in, we could do that now.

MR. LEVENSON: That's fine, Your Honor.

THE COURT: So I'm going to turn to the defendants and ask you this question. The deliberative process privilege applies in a particular context to protect certain candid conversations of an executive. This is slightly different. This is a situation in which a statute identifies the person providing the advice, identifies the nature of the advice that's being provided. So why would this be covered by the deliberative process privilege where -- where the Nevada has explicitly identified publicly who would be providing the information, what information would be provided, at least the nature of it, not necessarily the specifics of it.

That's highly different than, for example, some information we've received in this case where there have been individuals, which the Court has shielded, who have provided information. And the Court has not ordered that the consultation or the name of that person be provided because the

deliberative process privilege protected that person. And you all understand the person to whom I'm referring, or at least one of the people I'm referring. I'm not talking about that. This is a different situation.

So I want to hear from both counsel about that, because from my standpoint, I have to tell you, honestly, it seems that the legislature intended for this type of consultation given the immense public interest in this particular issue for the CMO's consultation and advice to be public. Otherwise, why reference the CMO and why say that the CMO had to consult on the actual execution protocol?

Ms. Ahmed.

MS. AHMED: Thank you, Your Honor.

And, Your Honor, unfortunately I don't -- I don't have the legislative history in front of me relating to that particular statute. The way I view it, however, Your Honor, is slightly different in that it's -- it's clear that the statute intended for the director to consult with the CMO. I agree with that. But it's not -- I don't know that that moves the conversation itself out of the deliberative process privilege from -- from the prospective I have having looked at the cases.

Because from -- from my understanding, the way the statute's phrased, it's clear that that conversation is pre-decision for the director. The director's the one that shall make the ultimate choice. He has to consult with the CMO,

and then after that consultation, he makes the choice. And so for me it seems clearly within the deliberative process privilege because that entire conversation, while -- to Your Honor's point, I get it, that maybe that was the legislature's way of saying, "You're going to have this conversation and that conversation's going to be known." But it's not clear to me from the statute itself that that's the case. That we want the actual contents of the conversation to be known as opposed to the statute saying you must have a conversation or consultation with the CMO. But --

THE COURT: Well, let me ask this question, Ms. Ahmed, about that. Because what I'm talking about is there are two aspects to this. One is the privilege is limited. It's not an absolute privilege. It's never been associated, for example, with the attorney/client privilege or other privileges which have much greater protection for different reasons. And I identified the purpose of the privilege because I'm required, when I determine whether or not it should apply, to look at that; to say, is this a situation that the privilege is intended to protect.

That's why I said the privilege is intended to protect candid, which typically means confidential, conversations, right. And that's also why I was saying I think the privilege would still protect the extent to which Director Daniels may have asked Dr. Azzam questions.

But where the statute is explicitly saying we want the CMO's opinion, right, of a public execution, right, how would that not take it out of, sort of, the type of conversations that the -- that the privilege was designed to protect? So that's one question.

The other question is, and this is a question that I'm going to ask you both, it does seem to me that there's a real issue in this case about whether or not this is actually predecisional or whether or not there is an ongoing process as it relates to the decision that Director Daniels makes.

The execution protocol is not final and, in fact, it won't truly be final until there's an actual execution because it allows for multiple decisions by the director up until the very moment even during the execution. So there's a real question for me, which I also want to get your opinion on, about to what extent does it fall within the deliberative process privilege where there's an ongoing consultive process. In such case, information would be relevant, particularly information that the director receives.

That -- the latter question 's a little bit longer, but why don't you take the first part of that, Ms. Ahmed, and then you can get -- take the second part.

MS. AHMED: I think that the first one went back to the Court's earlier point, which is that information itself is carved out from the -- from the privilege, right? So I

understand the Court's point on that.

If specific research was done and specific facts were given, that, I think, Your Honor, nonetheless -- not to be just a broken record, but nonetheless, to me, it all seems protected by the deliberative process privilege because it is -- there's two things.

A, this is the CMO going through a process of -- a candid process with the director trying to figure out what will work and what won't, and maybe there was research or maybe there wasn't. I'm speaking hypothetically. But, nonetheless, the actual decision is later made by the director.

So to me, even though -- and I -- maybe I'm answering the second question more than the first. But, Your Honor, I mean, to me it seems that the execution protocol, the decisions that are made, the sequence that's put in there, that's all subsequent to the conversation with the CMO, but it is not in any way -- it's exclusively the domain of the director to make that decision. And it's -- and it's clear from the statute, at least, that that's a decision he shall make after the consultation.

So even though the execution protocol itself might be revised, there might be subsequent consultations, the consultations themselves -- themselves constantly, at least in my mind, fit within the deliberative process privilege because it's, "Hey, I'm coming to you with this drug and this drug and

this drug. And can we have a candid conversation about how they'll fit?" To me, that seems squarely within the deliberative process privilege.

But I don't want to monopolize this discussion because, as the Court knows, we joined in NDOC's briefing on this. So I would want an opportunity for Mr. Gilmer to weigh in if I haven't covered anything on that.

THE COURT: Well, it does seem there is one central issue, which I can go back and look at, too, which is there's the question of legislative intent. I mean, this is a very different type of consultation than some of the other deliberations we've discussed in this case. And it does seem to me that if the legislature intended for it to be public, then obviously that addresses the issue here. So, again, if you all have a view about that, that's helpful, too. But I think, again, because he specifically identified, it's slightly different than someone's who's not.

But, Mr. Gilmer, tell me your view about a legislative intent here because of the identification of the CMO, but also just about deliberative process privilege. And I'm going to go back and look at this, but there is -- there is a strange issue here where the decision is changing and evolving, understandably, and that's the way that it -- it probably should. But how does that affect the analysis? So you can take both of those questions.

MR. GILMER: Yes. Thank you, Your Honor. And I join in everything Ms. Ahmed said prior to me. Very good counsel and argument on that point.

With regard to your specific question on the legislative intent, and I think I go back to the very first question you asked about, you know, the -- the opinion and that the -- did the legislature intend for the opinion that was provided by the CMO to be shared. And I would -- based upon my reading of the statute and the legislative intent that I've been able to delve into on that point, I would say the answer to that be would no.

And here's the reason why I would say that, because the statute is written so that the -- Director Daniels or the director of NDOC shall pick the drug or combination of drugs after consultation with the CMO. That's it. And so that means that the protocol goes into effect by director -- by the director after having that conversation. It does -- the statute doesn't say that the CMO must agree, the CMO must not agree, that the CMO -- it says consult.

And so at that -- the purpose of the statute is to put an emphasis on the director to finalize something after speaking to the CMO, and I think it was very -- it made sense that the Nevada legislature would want a director of Department of Corrections, who's most likely not going to be a doctor or somebody versed in medicine, to have those conversations before

making a final decision.

But, again, there's no duty put on -- on the CMO to agree or disagree with what the director puts forth. And so I think that that's a little bit different. Even though that person's identified, that's who the State of Nevada thinks the director should go get information from, but I still think that's different than saying that that means that what the CMO shares with him is -- is, therefore, becoming public because of that. And I'd like to analogize, obviously, to, like, the President of the United States, for example, conferring with generals or conferring like -- conferring with leaders of Congress under the War Powers Act before they decide whether or not to send troops.

Required to do that. Required to talk to them. Required to share them. But legislature or Congress didn't say, then, that those communications between the majority and minority leaders of the legislature have to be made public. It just says that the president has to go talk to them before moving on. And so I know it's a very different situation, but I think that's a pretty good analogy when referring to the difference between talking and consulting and whether or not it's actually meant to become public because of that.

Was there something -- did that answer everything you had, Your Honor?

THE COURT: Look -- yes, I think it did. I mean, I

think that, again, this is -- this is unique and it's different from other conversations we've had as relates to the deliberative process privilege. I do think it really does turn upon legislative intent here as it relates to what the legislature intended.

So let me turn to plaintiff's counsel as it relates to that particular aspect.

MR. ANTHONY: Thank you, Your Honor.

First of all, I would say, to be candid with the Court, we're not really -- we're not aware of anything specific in the legislative intent that speaks to this from our own review of the statute. I don't recall from the committee minutes whether there was any sort of an elaborate discussion of this particular subsection of N.R.S. 176.355 about what exactly they were intending. So just to be candid with the Court.

A couple of things that I would say, Your Honor, though, is that it appears from, at least, the plain language of the statute that the legislature considered this to be an important safety valve, something that the public could look at and rely upon, which was that the director of the Department of Corrections, who is normally concerned with safety and security and rehabilitation, is taking on a very important role here that's very different. And in that connection, it appears that the legislature wanted the public to know that there was a medical official involved in this consultation.

When we talk about the deliberative process privilege, Your Honor, it's our understanding that when the issue is the conduct of the Government itself and when that's relevant either to litigation, like litigation that we're currently prosecuting, or whether we're talking about freedom of information, which is kind of a different category, it's our position, and I think the case law bears this out, that when the Government's conduct is in question and whether -- when it's an element in the case, we believe that that's a circumstance where inquiries can be made.

Now, I agree that they could be limited. We're not asking for what did Dr. -- or, excuse me, what did Director Daniels --

THE COURT: So, Mr. Anthony, let me ask you this question, because we may be arguing around some of this actually fairly -- not insignificant, but a matter of semantics. He said his views as relates to the drugs. This is really just about one -- one question, right. But in the context of preserving the privilege, right, would it be more important simply to preserve that? Because it is a privilege that's a traditional privilege that covers these decisions. Why, in this context, is it so significant to ask that particular question?

MR. ANTHONY: Because the --

THE COURT: He --

MR. ANTHONY: If the director wasn't given that advice or if he didn't follow the advice of the only medical official

that he's statutorily required to consult, we believe that that's a relevant consideration.

THE COURT: And why wouldn't we wait until we had Director Daniels on the stand? Because -- and I'm not saying that's not true, but, I mean, when Director Daniels takes the stand, we're going to have lots of conversations about deliberative process and what's been shared or not shared because we have a very full record here.

So I don't necessarily disagree that, as it relates to the deliberative process privilege, the Nevada Supreme Court has said where the Government's actions are at issue, the privilege itself is not the same as it would be in other circumstances.

But for me the issue is, it's hard to know the significance of the one question until I hear from Director Daniels. You're right. You're saying that in the context of the information that he shared or relied upon, but I don't know exactly what he's going to say or what he's going to say about what information he has. You're perfectly able to and I will permit you to ask him questions about his knowledge and information. That's not covered by the privilege, right? And you can ask him different questions about that.

In terms of the sources, then we can talk about, perhaps, what we get into that. But, for me, it seems to me that one of the questions you're asking really relates to, to what extent did the director rely or not rely upon certain

sources of information in reaching the protocol. That seems to me to be the deliberative process inquiry for Director Daniels' testimony. It impacts what Dr. Azzam may or may not have said, but I don't think that I can fully actually even go into that inquiry until I hear from Director Daniels as it relates to the protocol itself.

So, I appreciate your argument, but I think that part of what I'm hearing from counsel, and this is why I'm saying this because I'm going to close this argument now is, one, and I agree with this, we've looked at the legislative intent. There's really nothing there, right. But it seems clear that there was an intention here for at least the director to have access to the information --

MR. ANTHONY: Your Honor?

THE COURT: -- in the context of this case. It also seems clear that this is different than other aspects of the privilege. But it also seems clear to me, Mr. Anthony, that the Court would be better situated to make this decision after hearing from Director Daniels. The Court appreciates the importance of the privilege, as I've said repeatedly, but it's difficult for me to evaluate that determination without hearing from him.

So I know I cut off your argument, Mr. Anthony, so I'll let you, sort of, finish it for the record. But I think that I need to wait until I hear from Director Daniels, and then we can

have this conversation -- because we're going to have the conversation, I would expect, repeatedly in the context of different questions to Director Daniels. And I think it would be more appropriate, because I do think there is a very important discussion to be had about the information and sources that Director Daniels had access to in the context of the privilege. But that's not for this particular witness.

MR. ANTHONY: Your Honor --

THE COURT: Go ahead, Mr. Anthony.

MR. ANTHONY: -- just a very, very brief comment. I certainly don't disagree with the Court that it's up to the Court's discretion to hear from one witness to determine whether something should or shouldn't be admissible. I have no complaints about that. One other thing that I just wanted to put out there because I didn't want to be remiss, is that I think there's also a very good issue of waiver here because Director Daniels testified about the substance of his conversation with Dr. Azzam. He already testified in great detail to it and it wasn't privileged, and it all came out at the deposition.

He talked about how, when he asked the questions to Dr. Azzam, that Dr. Azzam repeated what we heard him testify to on this --

MR. GILMER: Your Honor, Your Honor.

THE COURT: Okay. So, Mr. Anthony, if we want to have

a conversation about waiver, particularly in the context of his testimony, we can have that conversation. I mean, let's be clear. This is about a single question, right? Dr. Azzam is available to potentially come back and answer that question. It will take two minutes or less. It will take longer for us to swear him in than for him to actually answer the question.

So I'm not saying we wouldn't call him back, but I definitely think this is really an issue that has to be resolved in the context of Director Daniels' testimony in concert with other questions about Director Daniels' testimony. I'm not saying there isn't an issue of waiver here. I actually think there are issues of waiver, but waiver doesn't mean a waiver as to all questions. That's the other issue.

So one of the things that I did want us to talk about today in preparation for Director Daniels' testimony tomorrow, or at least part of it to the extent we get to it -- who knows with these other witnesses -- is covering the different aspects of the inquiry and what's been waived or not waived. Because waiver is not blanket. It can be as to certain aspects and not others. And I really want us to be very specific about this as relates to Director Daniels' testimony moving forward.

I do think there are clear areas where he may have waived and he did that intentionally, but there -- there are other areas where -- where he has and Mr. Gilmer has consistently protected, right? So, for example, the other

individual I referenced, there's been no waiver with respect to that. They've consistently protected that particular source of information.

Doesn't mean that I may not disclose, at least, some aspects of it, which we talked about previously. But it does mean that I don't find that there's been a blanket waiver of the deliberative process privilege.

So, that goes back to the Court's determination at this point in time that the decision about whether or not to ask Dr. Azzam the one specific question the Court will defer on. And then if we call him back, because I deem that he needs to answer that question, we can have him called back or we can reference portions of other proceedings.

I don't know that we need to call him back just for that, but we can talk about that later.

So is there any other thing -- any other question or issue we need to address with Dr. Azzam before the Court releases him?

MR. ANTHONY: Not from plaintiff, Your Honor.

THE COURT: Mr. Gilmer?

MR. GILMER: No, Your Honor. I have some issues pertaining to waiver, but we can defer that until that time. Nothing with regard to Dr. Azzam.

MS. AHMED: Nothing, Your Honor. Thank you.

THE COURT: Okay. Thank you, Dr. Azzam.

THE WITNESS: Thank you.

MS. AHMED: Your Honor, just logistically, if Dr. Azzam's travel plans were to return back home tomorrow, would he be allowed to be excused from the hearing from further -- for the day and tomorrow or do you want him to stand by?

THE COURT: No, no, he's excused from the hearing for today and tomorrow. And, look, I don't know that we need him to come back to answer this question. So I'll make that determination. I think it's a fairly straightforward answer one way or the other.

MS. AHMED: Thank you, Your Honor.

THE COURT: So he's excused.

That does raise this issue about Director Daniels and waiver, Mr. Gilmer, since you raised it. There's certain aspects of the protocol that Director Daniels has clearly talked about that potentially could have been covered. Or earlier on, actually, in the case, you were asserting the privilege to protect, which later Director Daniels said, "I want to talk about certain aspects, not everything, but certain aspects of that." It would be helpful to me to know where you all agree or disagree about those certain areas.

So, for example, conversations with Ms. Fox, that seems to have been, clearly, part of this process. I think they've all been testified to, essentially, but those would be

conversations that I think that potentially could have been covered, but that are not covered here where there may be, I think, clear indications of waiver. But, again, waiver's not blanket, it doesn't cover everything. I gave the counter example of other sources that have been consistently protected.

It would be helpful for me to know ahead of time where there's going to be disagreement so that I can think about that before Director Daniels testifies. Now, some of this, of course, has to happen while he's testifying.

There is going to be a fair amount of testimony from Director Daniels because the protocol is long, and it leaves to him certain decisions that would need to be clarified either by plaintiff's counsel or by the NDOC. And -- and Director Daniels has indicated, in fact, that parts of this he wants to be able to clarify. He doesn't want there to be information that isn't clear about that. So that's the other aspect to this, Mr. Gilmer, in hearing from your client. Director Daniels has been fairly straight about certain things that he thinks are important for the public to know even if there is a privilege that would cover them.

All of that is to say, I would like for you all to meet and confer about this first. I don't want us to spend two hours tomorrow going over where we agree and disagree. I think there can be clear areas of agreement here about what's already been discussed, and there may be some areas that are also clearly

identifiable where there's disagreement. But I want to repeat what I've said previously.

I don't believe information is protected. So to the extent that the Director Daniels received information about a drug or how it works, Mr. Gilmer, I don't think that's protected.

His evaluation of that information in terms of how or what weight he places on it, potentially raises an issue of the source of the information, Mr. Gilmer. I think -- I will say, I think the source may become an issue depending upon the weight that he places on information or not. Again, it's hard for me to know without hearing his testimony, but I want to give you all some broad outlines to help guide your conversation.

So clearly questions about his understanding of the drugs, how they may or may not work, what the complications may or may not be, what steps may or may not need to be taken, that, to me, is all fair game. And I see you shaking your head, Mr. Gilmer. I'm not saying you would object to that. I don't know that there could be an objection, but I do think that's information that he has in this case.

And questions about aspects of the protocol where he may have to make a choice are also going to be important. There are certain parts of the protocol where Director Daniels may have to make a choice about certain things. He may have to make a choice about which drugs in the protocol to use. He may have

to make a choice about when to stop or start a process, when to -- to set certain types of protocols or procedures that are still left to him to decide.

Those questions are open in the protocol and I think it's fair, Mr. Gilmer, for him to be asked about that where the protocol doesn't clearly identify that information, but it's clearly information that he would need to have or may already have in terms of making his decision.

The areas that I think there's going to be some disagreement is about any type of specific request about did Dr. Such-and-such tell you X, did this other doctor tell you Y. That, to me, is an area where I suspect there will be disagreement and where the privilege might apply. And, quite honestly, it's not clear to me where that would necessarily be relevant. What matters to me is what Director Daniels understood from all of this and what weight he places on it. That might then open the door, potentially, Mr. Gilmer, to certain questions about why he thinks certain things are more likely than others. I think that's also fair.

But trying to recreate which doctor said what at different times to me, I don't know that that's productive or would be appropriate to disclose in the context of the privilege. I'm providing this guidance because I'm hopeful that this will help to narrow the conversation because, Mr. Anthony and Mr. Levenson, there really isn't that much that I can see,

other than this conversation, that would be covered by the privilege that would be information you'd want to have that you're not going to be able to ask him, right? A lot of this is just about the protocol. What do these things mean? What does he know? How would he decide this?

They haven't objected to that. They're not -- as far as I know, that's not an objection that's raised. The objection for the deliberative process privilege, as I've seen it so far, has been relayed -- has been raised as it relates to providing a delineation of specific information from specific people, which is what the privilege, typically, is designed to do. But it has not been, as I've seen recently, once the protocol's finalized, designed to shield all aspects of Director Daniels' knowledge.

So, Mr. Gilmer, any comments on that?

MR. GILMER: Your Honor, I thank you for the guidance for us to talk about for the meet and confer. Not -- not bouncing in, but I think this is very similar to a conversation we had, I think, on November 5th at one of the hearings where I had said -- I think you had asked me about -- or maybe it was last time we were here. And I said, I think the information that Director Daniels used is probably, at this point, something that's fair game, but where he got that from and the source of that is where the disagreement is. So I think in that agree in that aspect. And hopefully we'll be able to limit that with regard to that.

The only thing I wanted to say with regard to waiver -- and, Mr. Anthony, I apologize if I -- if I talked over you, but I was just concerned that he might be giving information out inadvertently that was discussed there. I think the waiver with regard to Dr. Azzam is a -- is a more difficult question, because as the Court will recall, we called you during that deposition and you ordered Director Daniels to answer some questions.

So -- and the way Mr. Anthony portrayed that, I thought it made it sound as if he voluntarily did that, but, obviously, we did it under a Court order. So I think that's a different issue for us to discuss at a later time.

THE COURT: I agree. And that's a common practice in depositions, for information to be ordered to be answered for efficiency purposes, that's later protected, right, when a privilege is asserted. And that is never construed as a waiver where the Court orders an answer to the question, but the objection is preserved, and that's exactly my recollection of what happened. I did order answers, and I said that the objections were preserved and that I would rule on them later.

So I agree with that, and I don't think that that constitutes waiver simply because he answered. Now, if he answered a question where there was no objection, that's different. I don't -- I wasn't present at the deposition in its entirety, as you know. So you can still argue waiver. I'm not

saying that. But where I've ordered a witness to answer over an objection, that's not waiver and that information can still be protected even though it was disclosed in a deposition.

And that's standard practice as relates to deposition privileges. Otherwise, we'd have to take them multiple times, and that's not efficient.

So, let's move on from here. Who's our next witness then?

MR. GILMER: Your Honor, at this point, the next witness would be Dr. Jeffrey Petersohn. And I -- I'm very hopeful that we'll be able to get through his testimony today. So before we begin, it might be helpful if we knew what our endpoint was going to be so it can help me frame my questions, because I know the Court is very -- very fair in giving each person equal time. So if we know what time we're going to stop -- it said 4 or 5 on the -- on the -- on the trans -- or on the schedule.

Dr. Petersohn has a 7 o'clock flight. So we can go right to 5 p.m. if that works for the Court's schedule, and it's just going to help as we call him to know how much time we have.

THE COURT: So let's -- let's use 4 as our target.

MR. GILMER: Okay.

THE COURT: We've received a fair amount of information in this case, and so what I don't want you all to do is to go over some more of the more basic information, right? Is

fentanyl or whatever an analgesic? I mean, basic information that has been established by all experts, right, I don't know that we need to be going over with this particular witness. So I would ask you to look at your outlines and be specific.

So let's use 4 as our target stopping point, even though we may go beyond that. And we may go beyond that partly just to deal with administrative issues, so I want to save some time at the end for that. So even if we went past 4, we wouldn't go past 4:30. We may stay to 5 because I want us to be prepared for Director Daniels' testimony and anything else we may need to address as it relates to other issues for the coming weeks. So with that, let's use 4 as a target.

Dr. Petersohn, why don't you come on up to the stand.

MR. ANTHONY: Your Honor?

THE COURT: Yes.

MR. ANTHONY: Could I have a quick break, two minutes, five minutes tops?

THE COURT: Sure. We'll take a five-minute break if you would like to do that, Mr. Anthony, sure.

MR. ANTHONY: Thank you so much, Your Honor.

THE COURT: Of course.

(Recess taken at 11:26 a.m.)

(Resumed at 11:39 a.m.)

THE COURT: Please be seated.

All right. Doctor, if you could stand so we can swear

you in. And raise your right hand, please.

JEFFREY PETERSOHN, M.D., having duly been sworn, was examined and testified as follows:

MR. GILMER: Good morning --

THE COURT: Hold on. Can you state your full name and spell it for the record.

And, again, if you're comfortable with it, while you're behind the Plexiglas, you can take your mask down. You don't have to do that, but if you would like to, you can.

THE WITNESS: Thank you, Your Honor.

THE COURT: So could you state --

THE WITNESS: Yes, my full name is Jeffrey Petersohn, J-E-F-F-R-E-Y, P-E-T-E-R-S-O-H-N.

MR. GILMER: Thank you, Dr. Petersohn.

Your Honor, at this time to speed things along and consistent as we have been doing this throughout, I would ask that the following exhibits be admitted. And those would be Exhibit 513, which was Dr. Petersohn's initial report in this matter; Exhibit 514, which is his C.V., curriculum vitae; Exhibit 514 A, which is his list of testimony that was attached to the C.V.; Exhibit 515, which is his rebuttal report in this matter; and also his deposition, which was Plaintiff's Proposed Exhibit 115.

THE COURT: Okay.

Any objections?

MR. ANTHONY: No objection.

THE COURT: Okay. Those will be admitted.

MR. GILMER: Thank you.

(Defendant's Exhibits 513, 514, 514 A, 515, and Plaintiff's Exhibit 115 are admitted.)

MR. GILMER: And, Your Honor, also hopefully to speed up this process a little bit, I was able to have a conversation with Mr. Anthony before we began. And I thank Mr. Anthony for his professional courtesy in this regard. Mr. Anthony indicated that -- that plaintiff's position and we can stipulate that Dr. Petersohn is an expert for purposes of anesthesiology. Obviously, they reserve any rights to object to any particular question with regard to the scope. But I think that will help speed up the process with regard to the voir dire process.

THE COURT: I appreciate that. Thank you. So the Court will also recognize Dr. Petersohn as an expert in anesthesiology.

THE WITNESS: Thank you, Your Honor.

THE COURT: Of course.

MR. GILMER: Thank you.

DIRECT EXAMINATION OF JEFFREY PETERSOHN, M.D.

BY MR. GILMER:

Q. Good morning, Dr. Petersohn.

A. Good morning, sir.

Q. We thank you for having you here today. And I'm not going

to belabor much about your C.V. and your credentials since we have that stipulation and have it in the record. But I did just want to give a brief background so the Court knows who -- who's giving answers today.

So could you please tell us where you attended post high school education?

A. Yes. I hold an undergraduate degree in biophysics from the Johns Hopkins University, having graduated with a Bachelor of the Arts. I did my medical degree, my M.D., at Hahnemann University College of Medicine in Philadelphia. I trained in internal medicine at Hahnemann, and then in the middle of my training IN internal medicine, decided to switch into anesthesiology. I completed the anesthesiology residency at Hahnemann and have been in the private practice of anesthesiology and its subspecialties since completing that training.

Q. So I just want to confirm then, in answering that question, you can -- you also gave us information regarding your internship and residencies?

A. That's correct, sir.

Q. Thank you.

And what -- where do you currently work, Dr. Petersohn?

A. My present practice has offices in Linwood, New Jersey, and also in Englewood, Colorado.

Q. And what type of -- how would you describe your practice to

the Court?

A. My present practice is devoted exclusively to interventional anesthesiology and addressing and solving issues and concerns and problems of patients who have pain.

Q. And does that -- does that practice -- this might sound like a silly question to you, and maybe it is. But does that require you to perform operations and be in the OR setting or --

A. Yes, I do not just operative procedures, some of which involve injections and others of -- others of which are more conventional surgical procedures, including discectomies and foraminotomies, some things people might consider to be neurosurgery --

THE COURT: Dr. Petersohn, I'm going to ask you to slow down just a little bit.

THE WITNESS: Sorry.

THE COURT: That's all right.

THE WITNESS: I perform some procedures that are distinctly surgical, a variety of injection procedures, and I prescribe, and in some cases, administer many classes of medications.

BY MR. GILMER:

Q. And where do you currently hold medical licenses?

A. I hold medical licenses in New Jersey, Pennsylvania, and Colorado.

Q. And are you a member -- are you board certified in

specialties?

A. Not only am I board certified in anesthesiology by the American Board of Anesthesiology, I hold a subspecialty certificate of added qualifications in pain medicine from the American Board of Anesthesiology. And I also hold certification from the American Board of Pain Medicine.

Q. And are you also ACLS certified?

A. Yes, both ACLS and BLS training, and I recertify every two years.

Q. And can you tell us what ACLS and BLS stand for?

A. Yes. Basic life support is BLS, and that is, essentially, how does one perform CPR. Advanced cardiac life support is ACLS, and that is more concerned with how does one manage the airway, what drugs of choice are used in resuscitation and in what sequence and in what indications. And we maintain those. Those are required to be updated every two years.

Q. And, Dr. Petersohn, not to belabor the point further, if we were to look at your C.V., would we be able to see an up-to-date information pertaining to professional memberships and organizations and committees that you would be a part of?

A. Yes, I've served on a variety of national and regional committees. Most recently I was immediate past president of the New Jersey State Society of Interventional Pain Physicians. And I have been both a lecturer and senior workshop instructor for the American Society for Regional Anesthesia and Pain Medicine.

Q. And, Dr. Petersohn, I'm going to also ask that you just slow down a bit. We don't want to get the court reporter upset with us. Thank you.

And you've been retained at -- by my office as an expert?

A. I have.

Q. And what are your rates that you charge?

A. I charge $400 per hour for most of the work that we do.

Q. And are these your standard rates?

A. Yes, they are.

Q. And so the rate you're charging my office is the same as you charge anyone else?

A. Yes, it is.

Q. Dr. Petersohn, I'm going to move ahead now, and if you at any point in time want to look at the protocol, just let me know and we can go to that. But I think I'm going to be asking you general questions that won't require you to look at it. But, again, this isn't a memory test, so just let us know if you need to look at it and we can put it up. It's been admitted as an exhibit.

A. Thank you, Mr. Gilmer.

Q. Have you had an opportunity to review the NDOC protocol with regard to the execution in this case?

A. I have.

Q. And do you recall what drugs NDOC plans to use as part of

that lethal injection?

A. Yes. It's fentanyl or alfentanil, ketamine, cisatracurium with an option to use it or not use it, and then one of the salts of potassium, either acetate or chloride, whichever is readily available.

Q. And so far, the experts that have testified, and plaintiffs can correct me if I'm wrong, but I believe so far all of the experts have said that for purposes of this protocol, while there might be some subtle differences with regard to fentanyl and alfentanil, they're not -- not really anything that we need to get into. Do you agree with that?

A. I agree, sir.

Q. So if I use fentanyl while I'm asking a question or alfentanil, please know that I'm referring to both and please clarify if there's a concern pertaining to that. Okay?

A. The drugs are very similar in effect.

Q. Do you recall the dosages of the drugs that you just referenced?

A. The dosage of the fentanyl begins with an additional dose of -- initial dose of 2,500 micrograms, and that may be repeated. The dose of ketamine, I think it was going up to 1,000 milligrams. And the dose of cisatracurium, I think, was up to -- perhaps it was 200 milligrams, if memory serves, and then 240 milliequivalents of potassium.

Q. I think you -- I think the protocol will show that you have

a very good memory with regard to those numbers.

You mentioned the drugs also, but I didn't ask you for the specific sequencing. Do you recall the sequencing of the drugs that you referenced?

A. I do. It was exactly the sequence in which I reported the use of the drugs.

Q. So that would be fentanyl or alfentanil, then moving onto ketamine, then moving onto, possibly, cisatracurium, and finally the potassium chloride or acetate?

A. Yes.

Q. Did you discuss these drugs, the dosages and the sequencing, in your report?

A. I did.

Q. And you prepared an expert report in this case.

A. Yes, I did.

Q. Without reviewing those reports, and, again, we can go to those reports and probably will in a minute, do you recall which areas you were asked to opine on by my office?

A. I was asked in a general fashion to opine as to the -- the choice of drugs that were used, the expectable effects of the drugs that were used, complications or problems that might reasonably be foreseen with the use of these drugs, and I was asked to comment as to whether this would be considered a humane or painless procedure, and to comment on various methods of assessment and the timing and such relevant to the protocol.

I did not design the protocol. I have had no role in advocating for or against its use, and I have agreed, specifically, to address these drugs in terms of their expectable effects and side effects or complications so that this protocol, if it is used, is as humane as possible.

THE COURT: So, Dr. Petersohn, you know, as I have learned in this process about some of these drugs, one of the things we've heard from different experts is that some of these drugs like fentanyl and ketamine, we understand how they operate on the body. We don't actually understand why they work the way that they work. And so one of the things that some of the anesthesiologists have talked about is, we've observed the effects and we understand the effects because we see them when we use them. But we don't always understand -- we don't have a clear understanding of why they work as well as they do in terms of producing sedation. Would you agree with that?

THE WITNESS: Well, I would be happy to give Your Honor a lengthy treatise on the particular mechanisms of action of each of these drugs. I think, with respect, I would disagree that we have an extraordinarily good understanding of why these drugs work.

And as time has gone on and we have moved from the introduction of these drugs in the 1960s, here we are 50 years later, and for each of these drugs, we have a very good idea as to how these drugs work. We have physiological --

THE COURT: Well, let me ask you -- so let me be more specific. So one of the issues is chest wall rigidity.

THE WITNESS: Yes, sir.

THE COURT: But not understanding why that actually happens. I've gotten different answers from different anesthesiologists as to why that would occur in the context of the use of these drugs.

THE WITNESS: I can answer that for you, sir.

THE COURT: Okay. So -- because different anesthesiologists have said, "It's a phenomenon that we've seen. We don't know why it occurs in some people and not other people, but we do know why it occurs. We don't understand exactly why some people might have it and other people might not."

So can you explain that?

THE WITNESS: Yes. The -- the issue here has to do with the action of fentanyl and related compounds on an area of the brain called the locus coeruleus. This is well outlined in a 2019 article in the Journal of Experimental Pharmacology and Therapeutics.

THE COURT: Wait. So you have to -- even though I know you want to answer me, you have to lean a little bit towards the bar so she can hear you clearly.

THE WITNESS: And the author -- first author is Toralva, T-O-R-A-L-V-A. What we know about these drugs, Your Honor, is that these drugs affect the system in the brain which

maintains resting skeletal muscle tone. And the way these drugs work is that by suppression of certain aspects of the functioning of this circuitry within the brain, it increases the muscle tone resulting in rigidity. And at the same time that it does that, it also depresses the connectivity of the brain in such a way that it produces unconsciousness.

So the phenomenon of rigidity and the phenomenon of unconsciousness are intimately linked, and they are virtually the same thing because they were created by the same center in the brain.

The key here is to understand that when you get rigidity, you have to get unconsciousness. The reason that you see this in some clinical applications and not in others, these drugs are highly soluble in fat, and brain tissue has a great deal of fat, and the drug goes into the brain relatively quickly. Depending upon the speed and the total dose of fentanyl that's administered, there is a huge difference in how much of this drug is present at these small centers in the brain that create these phenomenon.

So when you give 50 or 150 micrograms of fentanyl over a couple of minutes, maybe 250 over three or five minutes, you don't necessarily reach a level in the brain high enough to create rigidity or loss of consciousness.

When you use a very large dose sufficient that the amount of this fentanyl in the area of the brain is high enough,

it then causes these phenomenon. So when we're looking at --

THE COURT: I'm sorry. So -- my understanding of what you're saying is that if you have a high enough dose of fentanyl, you're always going to have chest wall rigidity.

THE WITNESS: It depends. If you were to give 2,500 micrograms over a five-hour surgical procedure, you'd probably never see it as long as you gave it very slowly. Because the peak level would never rise high enough to activate those centers and to produce the phenomenon of rigidity and loss of consciousness. That's why when you look at old case reports about a rareness during anesthesia, there's a lot of anesthetic given at the very beginning of the procedure and relatively little, or perhaps none, later on in the procedure.

So the level doesn't stay consistently high enough to produce rigidity and loss of consciousness, which are completely and temporarily linked phenomenon.

So when we give a large dose of fentanyl and we give it rapidly, the level of that fentanyl rises dramatically and it's sufficient to then act on this area in the brain which produces both rigidity and a loss of consciousness.

If we give that same dose slowly over a matter of hours, we never reach that threshold where we activate the center in the brain that makes this thing happen.

THE COURT: Okay. So that's helpful. So what you're saying, if I'm understanding you correctly, is that this dose

you would expect based upon your expert opinion that there would be chest wall rigidity, but that the dose would have already induced a deep level of sedation by that point or unconsciousness.

THE WITNESS: That's correct. It would induce unconsciousness, and this is completely separate from the respiratory depression issues.

THE COURT: Okay. And so -- but you would expect there would also be chest wall rigidity in this case.

THE WITNESS: Yes, because those two phenomenon are linked and they are both produced by the same center in the brain at the same time.

THE COURT: But you're saying that people may not recall any discomfort as it relates to the chest wall rigidity because they would already be unconscious?

THE WITNESS: Because the unconsciousness occurs at the same time as they develop the chest wall rigidity, you have no appreciation, no perception of this. And that's been shown experimentally in papers, including Streisand, that the individuals who developed chest wall rigidity have no recollection of having developed it.

THE COURT: That leads me to another question, which is very unique in this circumstance. These drugs also have an amnesic effect, correct?

THE WITNESS: Normally, we don't think of fentanyl as

having an amnesic effect. But if it's at a high enough level that it produces unconsciousness, then that also decouples the ability to make memories.

THE COURT: So part of the issue here, Doctor, which is very different than in other situations, your patients wake up.

THE WITNESS: We intend for that to happen.

THE COURT: Right. This is a situation where that's not the intent.

THE WITNESS: Exactly, sir.

THE COURT: And I say that because the amnesic effect wouldn't be relevant here because there's no after for this procedure, right?

THE WITNESS: Your Honor's correct.

THE COURT: So there's a real question for me about whether or not in that situation the person would experience what they're experiencing, but not have had the benefit of the amnesic effect of the drug such that they wouldn't remember it even if it was a negative experience. How do you address that potential? Because it does seem to me where we've had these cases that have said there's been some awareness of what may have happened, even in some of these cases, I think, it was with fentanyl, right. It raises the question for me that in a situation in which you're not seeking to keep someone alive, that if your purpose is for them to actually die, in that moment where they're not going to benefit from the amnesic effect of

pain or suffering that they may encounter, they could experience it and we would never know because they would have already died.

THE WITNESS: Well, it's a very good question that Your Honor poses. But in the circumstances of the operation of the protocol as it is presented, the phenomenon of profound sedation occur within seconds. And when the rigidity of the chest occurs, there is an immediate decoupling of the ability to process sensory information and the emotional aspect of information, which would be supplied by an area of the brain called the thalamus, that goes away. And the pathways that the brain uses to support consciousness just turn off. It's like flicking a light switch. So --

THE COURT: So you're talking about being sort of brain dead.

THE WITNESS: Well --

THE COURT: Because there's differences -- I think there's references to being brain dead and then being -- other parts of your body sort of being dead where you can still have brain activity, but your body is not functioning in other ways. So I'm trying to figure out, as I learn in this process and hearing from different doctors, what you mean when you say that.

THE WITNESS: What you're talking about here is a complete decoupling. And with certain drugs like ketamine, ketamine interferes with the ability to process any information from the external world, and it also interferes with the actions

of the limbic system which provides us with the emotional content of an experience.

So ketamine acts on the NMDA system to completely sever that. Now, the cortex is operating, but it has no input. It has no awareness. And this is what we call dissociative anesthesia. So with ketamine, you have a complete severing of any of the inputs and the ability to assign any emotional quality to any experience --

THE COURT: So you're saying --

THE WITNESS: -- of the cortex.

THE COURT: -- you can't perceive, which is a fundamental aspect to either pain or suffering, what's happening in the other parts of your body. Even if you could perceive them that they would create those feelings, you can't because ketamine interference with the brain's ability to be able to receive the information that would allow it to formulate those feelings or thoughts.

THE WITNESS: Yes. That's accurate. And the way fentanyl works is that fentanyl, at high doses administered relatively expeditiously, when you have this phenomenon -- I mean, first of all, the profound sedation occurs relatively quickly. People just don't care. They find themselves euphoric. If you're standing at the table doing anesthesia, they'll tell you, "Well, I feel like I'm, you know, starting to go here," and it's not -- not typically a difficult event. It's

often pleasurable, in fact.

But when you are increasing the amount of ketamine -- I'm sorry -- the amount of fentanyl in the bloodstream quickly, you will get this chest wall rigidity, but the same phenomenon that creates the chest wall rigidity at that point turns off consciousness. It completely eliminates the part of the brain that says, "Hi, I'm awake." All right. So if you're not awake, if you're -- you know, you have a decoupling of any of the external inputs from the phenomenon that we call consciousness, so ...

THE COURT: So let me ask you a question about that. How do we know that? Is it because you observe the chest wall rigidity and the level of unconscious or is it because of self-reporting? Because one of the other issues that concerns me, Doctor, is that if you're relying upon self-reporting to make the determination about whether or not chest wall rigidity occurs during unconsciousness, but if there's an amnesic effect of the drugs, you actually have a missing input as to data. Because even the person wouldn't remember that it occurred before they were unconscious because they don't remember.

So part of my concern about some of these studies is there's a self-reporting aspect to the side effects that may be masked by the amnesic effect of the drugs. So in this situation, as I've said to you, we're not going to have that situation. So one of the -- my concerns as relates to some of

these studies is they all depend upon, it seems to me, and this is what I've seen, if there's a complication from the effect of the anesthesia, the person reporting that they had a complication.

Would there be some other way that we'd be able to know that as it relates to the studies so that I could feel confident that the studies are capturing in real-time a potential complication without relying upon, sort of, the amnesic effect, essentially, to say there is no complication? Does that make sense?

THE WITNESS: Well, Your Honor asked a very difficult question. And part of the challenge we have is that for us to do some of these -- these studies stretches the limits of what would be considered ethical investigations.

So we have good clinical studies that show us the phenomenon of chest wall rigidity occurring. We also have --

THE COURT: Can I just stop you for a second because there's also an issue about, how do they know chest wall rigidity is occurring? Is it the difficulty of intubating someone? Is it the limbs? In your experience, one, have you seen it and how did you identify it? And, two, how do studies identify it?

THE WITNESS: Yes, I have seen chest wall rigidity. I have seen myoclonic motions with these drugs. I have -- I have been there, done that, as it says.

But --

THE COURT: So how did you -- how did you see it?

THE WITNESS: Chest wall rigidity --

THE COURT: I'm sorry, how did you see it? Was it through the -- trying to intubate someone or was it through -- through their arms?

THE WITNESS: Well, in the context of an anesthetic for a surgical procedure, we have a mask over the patient's face. We have a hand on -- on the bag. We're delivering oxygen to the individual. And what you will see is as the fentanyl starts to work, the patient will gradually take shallower and slower breaths. And we will supplement this by putting a bit of force on the bag and inflating the -- the lungs to maintain adequate oxygenation.

It may rather suddenly occur that when we're trying to squeeze the bag, we're not getting any air in. And that's the phenomenon that we refer to as rigidity. Okay?

So this is a phenomenon that we observe because we are paying attention, in the case of a surgical anesthetic, to the compliance of the chest wall and our ability to ventilate the patient.

THE COURT: Got it.

THE WITNESS: That's very different from this protocol where, number one, there is no oxygen enrichment that's being provided nor are we actively managing the individual's airway

and breathing and gas exchange. So these are totally different contexts.

The same phenomenon occur, it's just in one case you are actively managing these because you know they can occur or they might occur. And in the case of the NVDOC protocol, it's essentially irrelevant to the operation of the protocol.

THE COURT: Well, but -- and that raises another question, though, which is you are supplying oxygen.

THE WITNESS: That's correct.

THE COURT: How would you know in a situation where you're not supplying oxygen that the person wouldn't experience some sensation of what was occurring in terms of the breathing earlier than what's reported? Because in all of these cases they have to be provided oxygen because it would be unethical for them not to be doing it, unless there was some sort of mistake, obviously, with the procedure.

THE WITNESS: Right.

THE COURT: But part of this I'm being asked to rely upon studies that are not recreating what will happen here, right? And so how do we know, for example, there aren't going to be complications that occur because you're not giving supplemental oxygen and they may -- and they may occur much more quickly because you're not supporting the person?

THE WITNESS: Well, there are two -- two sources that we can look to for this. There is an extensive literature on

overdose experiences, and as Your Honor may be aware, there were over 100,000 overdose deaths last year in the United States. Approximately two-thirds of these involved opiates, principally fentanyl and heroin and fentanyl family drugs. And what we know is that when -- when the EMTs arrived on the scene, that over half the patients had no pulse.

What's interesting is when you look at the experience in Vancouver, Canada, where they have supervised injections or safe injection sites, as it were, and you have staff that are trained to recognize these and intervene as necessary, what you find is that there are a fair number of individuals who have developed chest wall rigidity, who have -- there are a few that actually will develop these myoclonic movements or posturing, which is a response that shows us that parts of the brain have just stopped working, which is consistent with our knowledge of how this works.

But what's most remarkable is that there's no sensation really, truly reported that this is considered a painful experience by those who awaken or who are resuscitated when they're -- they're interviewed at a later point.

THE COURT: Right. But that goes to my other question though, Doctor. Wouldn't it be -- the best way to measure that be in the moment that the person may be -- before they either pass out or they -- or they became unconscious where they may be experiencing the loss of breath, wouldn't the best way to

measure that to be to figure out in the context of that type of an overdose, what are they experiencing in that moment? Because the amnesic effect will have kicked in, right, by the time that they have been resuscitated, and then you see my problem because --

THE WITNESS: I think I understand Your Honor's concern. The profound sedation produced by fentanyl occurs within seconds.

THE COURT: Okay.

THE WITNESS: The -- the individual also has a profound depression of the interest in breathing. So there is no subjective sensation of suffocation or shortness of breath. That's only generated when you have a desire to breathe. So since a high dose of fentanyl rapidly administers suppresses that (verbatim), there is no sensation that you're short of breath. You have the euphoric sensation of the fentanyl, but there is no sensation of being short of breath. There's no sensation of pain, because you've already blocked those receptors.

THE COURT: So, Doctor, how can you -- how can you say that there is a euphoric sense, but no sense of loss of breath? How can both those things happen at the same time?

THE WITNESS: Well, we can extrapolate from our experience with lower doses of fentanyl looking at the sensation of euphoria. And we routinely see our patients following the

administration of an anesthetic, and I have never in -- in doing several thousand anesthetics using fentanyl, I have never had a patient report that they felt short of breath. And I think the sensation of euphoria or of a lack of any sense of malaise or disease, if you would put it that way, that is -- that's pretty much universal with these drugs.

And in this context of this protocol, because you're using such a large dose --

THE COURT: Right. So I guess in those patients, though, they're receiving oxygen, though, right?

THE WITNESS: Well, those patients are receiving oxygen. So one would presume that if there were an opportunity because they -- they wouldn't have the effect of a decrease in oxygen, if there were an opportunity for the brain to function normally and to retain those memories or to experience those, you would expect that surgical patients would report this if it were occurring.

THE COURT: You mean in the moment that it was happening.

THE WITNESS: In the moment it was happening or they would recall it at a later point. And we have no evidence that either of those occurs in the patients that we care for for surgical anesthetics. So in a patient who is participating -- a patient or an inmate who is participating in the NVDOC protocol, the expectation here is that because in those individuals who do

have full oxygenation and do have maintenance of normal airway mechanics, since this group does not experience dysphoria or dis-ease or discomfort, it would be even dramatically less likely that an individual who has reduced oxygen in the blood, which translates to an inability of the brain to function, it is highly unlikely, even more so than in the population that we take care of surgical patients, it is most improbable, completely improbable, that the individual would experience discomfort or uneasiness or anything painful that would be related to the initiation of this protocol with fentanyl.

THE COURT: Okay. Thank you, Doctor.

Sorry, Mr. Gilmer, but we just got on a little bit of a roll there. But that was very helpful. I appreciate that.

MR. GILMER: No, that's -- that's quite alright, Your Honor. I was hopefully scratching out questions as you were asking.

THE COURT: Well, again, I want counsel -- just so you all can be aware, you can probably tell from my questions, right. We don't need to go into does fentanyl when properly administered create some level of sedation. I think there's some agreement about that. But what we're focussed on here are complications. What we're focussed on here is what could happen that could create suffering.

I don't think there's a disagreement that in the administration of these drugs, they can create sedation, but

there are potential questions for the Court about at these doses, which have never really been tried in this type of a setting whether or not there could be a real potential for substantial and significant complications.

And so, again, I want you all to focus your questions with Dr. Petersohn on that. We don't need to cover ground where there's some agreement about some aspects of these drugs. I just say that because it would be helpful, for me, to be able to explore that. That's why I asked those particular questions, because to me that's -- that's what's going to be helpful.

So, again, thank you, Doctor. I appreciate that.

THE WITNESS: My pleasure, sir.

MR. GILMER: Thank you, Your Honor.

BY MR. GILMER:

Q. I think Your Honor -- in the questions that the Court was asking you, it started with chest wall rigidity. But I think we may have had some discussion regarding respiratory depression in there as well. Am I correct in that?

A. Yes, sir.

Q. Is there anything else to add with regard to the answers that you gave the Court pertaining to respiratory depression and whether or not that would cause any discomfort or pain?

A. Respiratory depression does not cause discomfort. In fact, precisely the opposite. The brain suffering a lack of oxygen or with the accumulation of carbon dioxide impairs the function of

the cortex first, so there can be no conscious appreciation without the cortex functioning. And with the progressive and rather rapid decrease in oxygenation, the remainder of the brain will gradually cease to function.

THE COURT: Doctor, let me ask you about that, in part, because, obviously, this has become, unfortunately, more prevalent in the context of COVID, this sensation of not being able to breathe which has been described, obviously, frequently in literature and public statements related to COVID. Why is that not the same here? Why is it -- why is this different? Is it because of the drug's interference with the processing of the respiratory depression?

But it does seem to me that, you know, in these people experience some type of complications from COVID, there is this sense of feeling of not being able to breathe. Can you tell me how that's different?

THE WITNESS: Yes, the difference here is that with the use of these medications, these depress the brain's generation of a signal that there is decreasing amount of oxygen or that the amount of carbon dioxide is building up. So these drugs directly depress the brain's perception and, ultimately, the brain initiation of inspiration.

THE COURT: I see. So what you're saying is that the person may be experiencing exactly the same thing that a person who may be suffering complications from COVID are experience --

experiencing in terms of the inability to get full breath, but their brain is not able to access the fact that that's happening so they can't form a perception about the loss of breath that may be described by people when they -- when they are having a COVID complication.

THE WITNESS: No. I respectfully would suggest that's incorrect.

THE COURT: Well, that's why you're here.

THE WITNESS: If I may, sir?

THE COURT: Yeah.

THE WITNESS: The sensation of shortness of breath, with COVID, that's generated from certain receptors in the lung. They're called J receptors.

THE COURT: Okay.

THE WITNESS: Okay? So that's one kind of a problem where it's a peripheral input that says, "Hey, you know, you feel short of breath because the lung is basically generating that -- that sensation."

With the normal sensation when we're short of breath, it's because there's centers in the brain that respond to alterations in oxygen tension, carbon dioxide tension, and PH that tell us that we have to breathe. But without the brain having a signal that there's something wrong, we never develop that subjective sensation of shortness of breath.

So we never -- with the use of fentanyl in particular,

individuals don't have a sense of being short of breath. There -- there is no sensation that you have to breathe, therefore, there is no sensation of being short of breath. If you take the example of a deepsea diver and these folks do -- do rhythmic breathing, and then they go under water for extended periods.

The -- the issue here is what gives us that subjective sense of shortness of breath. It's the sense that we have a decrease in oxygen tension and that we're motivated to breathe because of that. If we don't have a sensation that we need to increase that oxygen tension, we have no sense that we're short of breath. So drugs like fentanyl suppress that by reducing the inputs to the brain that say, "Hey, dummy, take a breath."

THE COURT: Right.

THE WITNESS: All right.

THE COURT: So then explain to me, if it's reducing the inputs, how is it all -- is that what's also reducing the breathing? Because -- because you're talking about two separate things, right. One is not getting input to the brain about the fact that you have reduced oxygen.

THE WITNESS: Correct.

THE COURT: But the other is, why is there reduced oxygen in the first place?

THE WITNESS: The brain doesn't have -- the brain doesn't figure out, necessarily, why there is reduced oxygen.

The brain responds to --

THE COURT: No, I understand that. What I'm saying, but why is there depressed respiratory -- a depressed respiratory effect, apart from the fact that there's interference with the -- the brain perceiving that? Because one is the brain's -- you're saying these drugs interfere with the perception.

THE WITNESS: Correct.

THE COURT: But if they didn't interfere, still, why is there -- why is there depressed respiratory function anyway?

THE WITNESS: There -- well, first of all, there are a couple things here. There are some effects of opiate drugs, including Morphine and fentanyl, on the brain that -- I'm sorry -- on the lung that decrease the sensation of shortness of breath. So, for instance, in the circumstance of pulmonary edema, you can give someone Morphine, you can give someone fentanyl, and that will reduce the sense of shortness of breath and, to a degree, will in some cases alter the pulmonary pressure and will actually improve pulmonary edema.

If you're looking at the effect on the brain, fentanyl has effects on these, what are called, Mu opiate receptors. And some of these will suppress the sensitivity of the brain to falling levels of oxygen by reducing that. There is no motivation to take a breath. There is no sensation of shortness of breath because you just don't have the input that says, "Your

oxygen's falling, you got to take a breath."

And at the doses that we're using in this protocol and with the speed of injection, you then have the effects on this other portion of the brain that disconnects consciousness.

THE COURT: So okay -- so, again, I appreciate --

THE WITNESS: So all of these things are going along at the same time.

THE COURT: So if I understand you, there's two parts of the brain that are being affected. One is in terms of our ability to breathe, we rely upon parts of the brain that tells us, essentially, sort of, what our gas levels are.

THE WITNESS: Yes.

THE COURT: And then send signals, even unconsciously, to our lungs and our chest to try to compensate or deal with that in terms of our breathing. And you're saying, one, the drugs interfere with that, sort of, adjustment system such that if there's a reduction over time, it's not steadily increasing. So it will just continue to reduce and reduce. And the other thing you're saying is that at the same time that's happening there's a separate part of the brain that would perceive the sensation of that reduced oxygen that's also being impeded by these drugs. Is that a fair summary?

THE WITNESS: That's a fair way to look at this.

THE COURT: Right.

THE WITNESS: And then you've got the third part where

the -- the operation of the fentanyl, there are specific nerve cells in the brain that help maintain normal skeletal tone and they maintain or allow consciousness to occur. And with high doses of fentanyl that are administered relatively rapidly, you suppress the action there. So that's what gives you not only the chest wall rigidity, it gives you the complete disconnection and the loss of consciousness.

THE COURT: Okay. Thank you, Doctor.

THE WITNESS: You're welcome, sir.

BY MR. GILMER:

Q. Dr. Petersohn, at one point during those excellent questions and your answers there was discussion about reduced oxygen. Is that -- is that -- is reduced oxygen connected to hypoxia?

A. Yes.

Q. And based upon the level of fentanyl called for in the NDOC protocol, how quickly would you anticipate hypoxia to occur?

A. If you were looking at a pulse oximeter in someone who is breathing room air and just watching as -- as this -- this plays out, you would start to see a reduction in the -- the amount of oxygen in the bloodstream, what we call hypoxemic. You would start to see a decrease in oxygen saturation probably within 30 to 60 seconds. And some of that has to do with the fact that the machine averages the signal over periods of five to 15 seconds. So the reduction in the oxygen in the blood occurs relatively quickly and goes from levels that are consistent with

life to levels that are inconsistent with consciousness. And relatively quickly, after about four minutes when you're not breathing, that's it. And it's considered unrecoverable neurologic function.

Q. And also just to clarify briefly, if you could put 533 up on the screen briefly.

You mentioned the Streisand article at one point when talking to the Court. Is this the article that you're referring to?

A. This is the article, sir.

Q. And that's in the record at 533. I just wanted to confirm that that was the same article that you were referring to.

A. Yes, sir.

Q. Now, does -- is fentanyl or alfentanil generally have what's referred to as a ceiling effect?

A. Well, in theory all drugs have a ceiling effect, but it's a little bit like the number of grains of sand in the beach. We know that that's a finite number, but no one has actually been able to count is precisely. And it's the same way. When we finally have enough drug on board that we fully saturate all of the sites for these drugs to have an effect, that would be the ceiling dose.

THE COURT: So could the ceiling dose be below what's called for in this protocol?

THE WITNESS: (Pause.) It's possible. It is certainly

possible and I think it's expectable. We often look at dosing in regard to what is required, for instance, with -- with an anesthetic to prevent the sensation of pain associated with an incision or with medical pinch. So we tend to look at the effective dose for 95 percent of the population. And we tend to look at how effective these medicines are and what dose is required in terms of establishing parameters to guide human administration of these medications in the therapeutic context.

THE COURT: And let me just ask one quick question. Have you ever given these medications and these doses in this sequence this quickly to any patient ever?

THE WITNESS: The only drug that I have given in anywhere near this dose would be just fentanyl as part of an anesthetic for cardiac surgery. And --

THE COURT: Would you give it in this time period?

THE WITNESS: No, no. You would stretch this out over a longer period, but high-dose fentanyl is a very common drug that's used for cardiac anesthesia.

THE COURT: In the time frame that's in the protocol, what's the largest dosage that you've ever given of fentanyl?

THE WITNESS: I think we're probably talking 500, but no more than 1,000 micrograms.

THE COURT: Okay. And what about ketamine?

THE WITNESS: Never. I've never given anywhere close to these doses for the purposes of a surgical anesthetic.

THE COURT: Okay. So you're saying that you would expect that you would hit a ceiling effect for both of these drugs, particularly in this sequence?

THE WITNESS: We're looking at circumstances where for each of the drugs that are discussed, we are looking at having a dosing that is going to far exceed any conventional clinical experience. So we're overdosing each of these drugs in order to be -- be assured that the design of the protocol will be carried out.

THE COURT: So that, of course, leads to one of the questions I have to ask, which is, how do we know what will happen at that point? And I say that because the body, at least from what when I've read, has different ways of dealing with medications which it can no longer either absorb or process. How do we know that once these drugs reach their ceiling effect, they may not have some other effect that we can't anticipate because the body has never intentionally been exposed to this dosing in this sequence --

THE WITNESS: Well --

THE COURT: -- ever.

THE WITNESS: -- it's an interesting question that Your Honor asked, but we come pretty close to these overall doses of fentanyl. So we have a very good idea of how the body is going to handle this dose of fentanyl. And we have so much experience with the use of fentanyl in conventional clinical contexts that

it would be disingenuous for anyone to opine that we have no reasonable knowledge or predictive ability to foresee what will happen with that drug.

THE COURT: Well, but here's what I'm saying about that. I'm not talking about whether or not you have a reasonable or educated guess about this because you haven't had this experience. The question is, how much of a possibility is there that in this time period where you're talking about, sort of, the rapid, relatively speaking, administration of very high doses of these medications that there couldn't be something that we couldn't predict just simply because that's never been something that's been done and our experience is based upon a completely different situation in which people are being monitored and maintained, there's been titration of these drugs.

And so what I'm trying to figure out is, how useful is that information of predicting this very different circumstance. So tell me why you think, for example, administering that amount over hours would be equivalent to centering it in three minutes.

THE WITNESS: Well, I think I understand Your Honor's question.

We certainly have very good evidence from the literature on drug overdoses with opiates as to what to expect with these very high doses. And what we can see in this population and what we see to a degree in -- in cardiac anesthesia is the production of chest wall rigidity. That's not

at all uncommon.

And we also see that the profound sedation and the target expectable effects of these drugs, the sedation, the profound suppression of any desire to breathe, the profound somnolence -- and we refer to it as euphoria. I wouldn't call it joyous, but the lack of a sensation of discomfort. Those effects are so profound and they occur so rapidly after the administration of the drugs, Your Honor's concern that there is some sort of off-target effect that we would not reasonably expect is not a reasonable speculation.

There is no evidence to suggest that that would ever occur, because we have experiences with very high doses, even if the context of the administration is drawn out a little bit. We have a very good sense, especially from animal studies where some of these super therapeutic doses have been looked at or, for instance, where drugs like carfentanil were used, which is far more powerful and more potent than fentanyl itself or alfentanil. We have experience and laboratory information as to how these drugs act.

THE COURT: So in those studies, you're saying they've given these types of dosages?

THE WITNESS: In -- in situations, especially with use of carfentanil, the equivalent doses that are given are very consistent with the kinds of things that we're seeing here. And Julie and Stanley did a lot of this research, I believe, in

1970s-1980s at University of Utah. So there is certainly a body of information about this.

And I think this is pretty well-known within the field of anesthesiology. With regard to ketamine --

THE COURT: Let me ask you just quickly since you referenced those studies, at those levels of carfentanil being administered, were there any complications observed besides chest wall rigidity of these animals?

THE WITNESS: There is a famous video of Dr. Stanley spraying carfentanil in a cage with a monkey, and the monkey very quickly becomes sedated and collapses. And after a period of -- of time, the monkey regains function, I believe.

So there is some evidence as to what we might expect here.

THE COURT: Okay. Thank you, Doctor.

THE WITNESS: Sure.

THE COURT: And one, sort of, final question. It seems to me that one of your sources for this conclusion relates to the fact that it appears based upon the overdoses, which may approach some of these higher doses of some of these drugs, although albeit a synthetic or polluted version of some of these drugs. Even in those contexts from what you've seen in terms of the studies, you haven't seen anything that would suggest a consistent identifiable complication beyond chest wall rigidity. Is that right?

THE WITNESS: Well, if one looks at the overdose studies, most of these, there are a fair number that result in death. But in the situations that someone would develop chest wall rigidity or even some of this, what we call, myoclonus, which are, sort of, uncoordinated or unpurposeful movements, these do reverse with large doses of Naloxone, Narcan. So we have evidence as to how to manage these. But I think --

THE COURT: Well, that wouldn't be happening here, right?

THE WITNESS: No, no. We would not anticipate that --

THE COURT: They wouldn't be administered --

THE WITNESS: -- in the proper operation of this protocol.

THE COURT: Right. So -- and describe to these me these body movements and why they occur.

THE WITNESS: These occur because that -- that little portion of the brain that is responsible for maintaining normal resting skeletal muscle tone is depressed by high doses of fentanyl. And because that -- that is depressed, that's where you get the chest wall rigidity, and that's where you get these -- these, we call, posturing. So that's -- that's part of the expectable response to opiate drugs.

THE COURT: When you say "posturing," can you tell me what that means and what that looks like.

THE WITNESS: You might see an individual who would

have their limbs in flexed positions or, alternatively, in fully extended, what we refer to as decorticate and decerebrate posturing. And these are the results of suppression of function of certain components in the brain that we tend to think of as maintaining protective postures or behaviors. So this is all done as the individual's completely unconscious -- unconscious. There's no pain or suffering that we are aware of that goes on with this. And, in fact, if you interview a trauma patient who has been successfully resuscitated and such, they have no recollection of any of the events that occur.

THE COURT: But -- but would you expect to see posturing and movements at these dosage in this protocol?

THE WITNESS: My sense is that we would expect to see chest wall rigidity, and I think because the dose here is so large and it's being administered quite rapidly, I think the likelihood of seeing posturing is pretty remote.

THE COURT: And would you expect in this case the -- the administration of the fentanyl and the ketamine to cause death before the potassium is administered?

THE WITNESS: It is possible.

THE COURT: Okay. Because of depressed breathing.

THE WITNESS: Because of depressed breathing, the lack of supplementary oxygen, yes.

THE COURT: Thank you, Doctor.

Go ahead, Mr. Gilmer.

BY MR. GILMER:

Q. And I think the record is clearer previously, but you mentioned that you would expect to see the chest wall rigidity in answer to the Court's question. Is it still fair to say, though, that you wouldn't expect any awareness or discomfort because you believe the person's under profound sedation?

A. The individual will have no consciousness so they cannot experience pain or suffering.

Q. I want to move on. I think we may have touched on it briefly with the Court's questions, but I want to ask some questions to you about pulmonary edema.

A. Yes.

Q. You were here for Dr. Zivot's testimony?

A. I was.

Q. And at one point in his testimony -- and I'm going to quote right from it. We can put it up if we need to, but this is from his transcript, at 1117, ECF number 263, Page 122. It begins at line 18. Dr. Zivot said, "And I speculate that that acid then travels to the lungs and may be the source of the problem with execution because pulmonary edema is seen in midazolam injections as well. The PH of midazolam is like 2.5 to 3.5, another pretty strong acid."

Do you remember that testimony?

A. I remember that testimony.

Q. Do you agree with Dr. Zivot's speculation that PH levels

have something to with the pulmonary edema that might occur? Assuming -- or, actually, let me back up. Do you believe pulmonary edema will occur in this instance?

A. It may very well occur, but I believe that Dr. Zivot's explanation for it is outrageous and has no science to support it.

Q. And can you please explain why you have that opinion.

THE COURT: Well, why don't you -- first, it would be helpful to explain why you think it will actually occur. And then you can talk -- you can answer the second question, but it would be helpful for me to understand.

THE WITNESS: There are a couple of reasons that you could have pulmonary edema. One of them is that in the dying brain or even in a brain that's still functioning but not necessarily conscious, the vocal cords may snap shut as a protective response. This is when we drink water, the vocal cords close to prevent us from inhaling water. So that's a normal physiologic reaction that we count on every day when we consume meals and beverages.

But in a situation with high-dose opiates or in a situation where there's little secretions on the airway and we don't have a completely normal protective reflexes, sometimes the vocal cords snap shut. And when the vocal cords snap together and we take a deep breath, this is what's called negative inspiratory pressure pulmonary edema. In other words,

the physics of generating negative pressure allows fluid that's in the blood vessels around the alveoli and the lung, the air sacs, to be drawn into those air sacs. It's not exactly drowning. It's not the way -- it's not as severe typically as in a COVID patient initially, but it's something that in clinical anesthesia we will address with intubation of the airway, positive pressure, and drugs that will help to remove the edematous fluid.

In this circumstance, we have an unconscious individual, and the problem here is the fact that the -- there is no consciousness, there is no pain, there is no suffering, doesn't mean that part of the brain says, "Oh, diaphragm, move, take a deep breathe in," but it has no way of knowing that the airway is already occluded as a protective reflection.

THE COURT: So, Doctor, I'm a little confused, though, because I thought you said the brain was essentially saying, "Don't breathe." But you're saying part of the brain is saying, "Breathe." Part of the brain that's monitoring the gases is saying, "Well, you're not breathing properly." So help me understand that -- that dichotomy. Because on the one hand you're saying there's some part of the brain, even when the person's unconscious, that's telling the diaphragm to move.

THE WITNESS: Well, here's the problem, Your Honor. It's a graded response. So if you go from breathing 20 times a minute to breathing once in two minutes, when you take an

attempted breath after a period of time, you may be completely unconscious, but it doesn't mean that you have absolutely no signal from the brain that says, "Breathe."

Now, there's no sensation that you're short of breath. The individual is unconscious. So there's no perception of pain, there's no sensation of suffering, but this is just a phenomenon that occurs in a dying individual. This happens -- somebody falls overboard, you know, into cold water, and they suddenly take a gasp. The vocal cords oppose. That phenomenon will last for several minutes. They never have a chance to -- to breathe again. They're dead. They're -- this is the mechanism of sudden death that occurs in these kinds of circumstances.

And the individual takes -- tries to take a breath against a closed glottis, they can't do it, and death results. So we know a good deal about how this phenomenon works.

THE COURT: But not -- in that situation, a person's actually aware of that happening.

THE WITNESS: Uhm. Yes. Here's a situation where you have someone that is not conscious and there is still some action that says, you know, to the diaphragm, "Go ahead and take a breath in." Now, it's not a deep normal breath that the individual would take because they don't have the drive to breathe fully, but even a vestigial attempt to breathe against vocal cords that are closed will generate the negative pressure

which will create this pulmonary edema.

THE COURT: Okay. I guess -- and so you would expect that that would happen here, but it would happen after the person who is subjected to the protocol was unconscious.

THE WITNESS: That's correct.

THE COURT: Okay. One other question I have, I don't know if you've actually studied or looked at other executions where they used opiates where they had to administer multiple doses. Have you looked at that?

THE WITNESS: I have heard of these, but I have not separately studied these, Your Honor.

THE COURT: Okay. Well, you have heard about them being described you saying? You've heard of them?

THE WITNESS: Yes, I have, sir.

THE COURT: How would you -- and some of them were not --

(Court reporter clarification.)

THE COURT: Some of them were not at quite these doses, but they were high doses. How would you explain the situation in which the person was still conscious potentially and had to be administered multiple doses.

THE WITNESS: Well, there are two phenomenon.

THE COURT: Okay.

THE WITNESS: One of them, Your Honor, is simply lack of adequate intravenous access. So in many cases, drugs have

been administered, but instead of going directly into the vascular system by the vein, they are pooling under the skin where absorption is very slow. And, of course, you're not going to have the rapid effect that you would anticipate with the proper operation of the -- the present protocol.

The other is there are, certainly, variations in an individual's response to drugs, and it's important that when you select an initial dose level that you select a dose level that's high enough that it makes it completely unexpectable that you're going to not have that response, which is the reason for the protocol's existence.

You also in this protocol --

THE COURT: Let me stop you for a moment there. We've had prior testimony, and I don't know if you've been listening to the testimony, from a pharm M.D., a clinical pharmacologist, who had indicated that there's a way to be able to test for how resistant someone might be to the effects of some of these drugs. Do you agree that that exists?

THE WITNESS: There are ways to look at that, but in the circumstance where the dosage you have chosen is so overwhelming, even in the circumstance where you might have genetic variations in susceptibility or where you might have someone who has -- who's been abusing opiates in the past, then you would expect a decreased response. But these are few and far between. And by choosing a sufficiently large dose, you

can, essentially, obviate the likelihood that you will not have an inadequate response.

THE COURT: But if, Doctor, we don't have real tests of how often these doses are administered in this rapid time frame, how often -- how would we know that such situations are few and far between if, in fact, we don't have any way to know that in terms of studying it? So we can look at overdoses, but, again, those are, certainly, not ideal situations, one, because the nature of what's actually been either ingested or somehow taken into the body. It's certainly going to be different than the pure form of some of these medications.

But how would you know, for example, this information? Again, because that's a central question for me, which is we're doing a lot of extrapolating because we don't, generally, for ethical reasons ever give these types of medications in these dosages. So how would you know that the people who may be resistant to them at these doses are few and far between?

THE WITNESS: Well, Your Honor, we do have, as I mentioned, what is called an ED-95 the expected dose that will adequately deliver the intended effect. And we have this for a variety of drugs, not just the drugs in this protocol.

THE COURT: Okay.

THE WITNESS: But in the circumstance that we have -- have this, because of the way the response to these drugs can vary, we're dealing with what we would refer to as the end of a

curve. And we've got a pretty good idea as to how far that's going to go out. And by choosing a sufficiently high dose, it essentially renders it to a reasonable standard impossible that we are not going to have the desired effect, presuming that the IVs work properly, that we -- we will have the effect that the protocol is designed to achieve.

THE COURT: What would happen if the drugs were not properly administered? What would happen if you had sought to administer this dose and it went into the muscle, and people didn't realize that, instead of the vein? What would happen?

THE WITNESS: Well, you would be relatively quickly aware. You would see, for instance, that you don't -- the drips in the chamber, in the IV chamber, would stop. So you would know very quickly when you are not administering a drug into a vein. And it's my understanding that this protocol requires redundant intravenous access, so you have two IVs. So you would switch to your other IV set and administer drugs through the other IV set. And, again, you --

THE COURT: How long does that take, by the way?

THE WITNESS: To switch a syringe?

THE COURT: Yes.

THE WITNESS: Fraction of a second. We do it all the time.

THE COURT: So is it -- what would it involve just from a mechanical standpoint, just so I understand?

THE WITNESS: We grab the syringe, rotate it counterclockwise, move over to the other tubing, insert it, rotate it clockwise, and inject.

THE COURT: Right. Well, you -- but that -- you're presuming, and this is an important part of this, that the person would have to have some experience with using these types of syringes and this setup as relates to intravenous medication.

THE WITNESS: They really don't need to have a great deal of experience. It's my understanding that there is an EMT in the room and, gosh, you know, these folks are experts in field resuscitation, management of airways, administration of drugs through IVs. The people who are drug administrators, they certainly have, you know, training to be able to go and attach and detach --

THE COURT: Hold on. Well, let me ask, have you been provided information about the background and training of the drug administrators?

THE WITNESS: I have not.

THE COURT: Okay. So, again, I just -- part of this is we're starting from, basically, not scratch because there's a presumption that they would be trained, but I'm trying to figure out what types of training or education or background they would need. And so you're saying that someone would, at least, need to have some familiarity with being able to -- to switch syringes. You think that that can be training that would be

available for a variety of different medical professionals, but they would have to have that experience at least.

THE WITNESS: I've been advised that the -- it is the intention of the warden to make sure that there are not just training, but there are run-throughs to ensure that everyone knows what should be done, how it should be done, and, essentially, mock experiences so that when the protocol is used, everyone understands what to do, what to look for, how to do it. You could certainly --

THE COURT: And let me ask you, would you be concerned if that didn't occur?

THE WITNESS: If there weren't training?

THE COURT: Yes.

THE WITNESS: Yes, I would be.

THE COURT: So the second question is, who advised you as to what the training would be?

THE WITNESS: I believe in conversations with Mr. Gittere, he advised that the -- the State has a formal program that it will put in place to ensure that individuals are trained to be able to do this properly.

THE COURT: Okay. Were you presented with that program?

THE WITNESS: I was not.

THE COURT: Okay. I just want to check. Mr. Gilmer, is there any presentation of a formal program by Deputy Director

Gittere?

MR. GILMER: No, Your Honor, this was -- not to speak for Dr. Petersohn, but my understanding the only time he's ever spoken to DD Gittere was during site inspection. So I believe these were questions that were asked during the site inspection.

THE COURT: That's fine. Again, I wanted to make sure that there's not something that's there.

Is there at this point in time an actual formal training protocol, Mr. Gilmer?

MR. GILMER: I do not know the answer to that. We will have an opportunity to hear from DD Gittere.

THE COURT: Why don't we just ask him? He's here.

MR. GILMER: Sure.

DD Gittere?

Not at this time.

THE COURT: Okay. And part of this is, again, I'm not ruling one way or another ab out when that would have to be, but I want to be clear in the record, Mr. Gilmer, about when things do or do not exist. Because in the past, as you know, there's been statements that the State may or may not have had information that they didn't share and then you later responded to.

I didn't want you to be in a situation in which the State was somehow accused of not providing information that it had. And, again, I'm not ruling way one or another about the

timing of that, but I didn't want there to be somehow this perception that there existed something that hadn't been produced. As you know, that has been the subject of some back and forth in this case.

MR. GILMER: Yes, and I appreciate you looking out for the State in that regard, Your Honor.

THE COURT: No, again, because I just wanted to be clear. And, again, we can talk about when or how. I'm not getting into that. I'm not making any determination about the appropriateness or not of the timing of that at this point. But I just want to be clear about what documents do or do not exist so we don't have any disagreement about that and we don't have statements back and forth about that. And so that's why I asked those questions at this point in time.

Now, the other thing I was going to say to you all, it's about time for us to take a lunch break. I think, actually, we're going to have to switch out some -- some staff here. Is there any reason why we couldn't take a break now and come back to finish up with Dr. Petersohn?

I'll try not to ask so many lengthy questions, but you've been very helpful in clarifying some of the things that have been left unanswered for me at least, Dr. Petersohn, so I appreciate that.

But, Mr. Gilmer, I know that I have, sort of, used a lot of the time. But I do think, as I've said, a lot of this

time has been around issues that, in fact, have been discussed by both sides. So I'll give you an opportunity to think about what you think may be left.

But, again, for the Court, really, I am focussed on the issues that I've talked about as it relates to, sort of, complications, administration, who may or may not need to be part of the training, what types of training. These are all questions that we've talked a little bit about, but that are going to be the focus of some of my questions, just to give you all some sense of that. I'm sure they would be of yours as well, but I just wanted to give you some information about that.

Mr. Gilmer, apart from the Court, what -- how much more time do you think that you would need?

MR. GILMER: Oh, Your Honor, I will have a better answer for that after our break. And I am fine, obviously, with the Court's indulgence, the shorter the better as far as I'm concerned. But I think you have done a very good job of going through most of my questions. I think there's just a few other things I'd like to ask pertaining to ketamine, specifically, and then the site inspection, and then also in response to some additional things that Dr. Heath or Dr. Zivot said.

THE COURT: So then it looks like we'll have maybe another hour, let's say, for direct to be generous.

MR. GILMER: Yeah. And I'm hopeful it will be -- again, obviously, wanting the Court to be able to ask whatever

questions the Court needs, I think I can definitely get it done even before an hour.

THE COURT: Okay. And then maybe an hour and a half or so from cross. I don't know. Maybe longer. I'm not sure. Again, I would suspect, Mr. Anthony and Mr. Levenson, some of the questions have been asked by the Court that you all had asked previously as relates to things like chest wall rigidity, but I will let you look at your outline.

Assuming we get through Dr. Petersohn's testimony today, who would we have after that, if anyone, or would we break for the day?

MR. GILMER: We can discuss that, Your Honor.

(Defense counsel conferring.)

MR. GILMER: We could -- I know at one point the Court said that they might have some questions for Deputy Director Gittere. We were planning on calling him tomorrow but -- you know. So I'm not sure we're totally prepared, but we could, obviously, put him up today.

THE COURT: I don't have any questions for Deputy Director Gittere at this point in time.

MR. GILMER: Oh, okay.

THE COURT: I think that we may have some later based upon what may happen later in this case. But, you know -- in the coming week or so. But as relates to this particular series, I don't have any questions for Deputy Director Gittere

at this point in time. I know that we have to come back at some point to Dr. Yun. I'm not sure when we would do that, but I think that's tomorrow.

MR. GILMER: Yeah, he's not available today, Your Honor. Just as far as for the Court's clarification, the only other witnesses we would call would be, potentially, Deputy Director Gitter and then, obviously, we know the Court wishes to hear from Director Daniels. We do not intend to call any other witnesses given the previous stipulation we've agreed to with plaintiff's counsel with regard to Chief Pharmacist Fox -- Fox's deposition being admitted pursuant to the redactions.

THE COURT: Okay. That makes sense to me.

Mr. Anthony?

MR. ANTHONY: Nothing much to add, Your Honor, except we had spoken a while ago about the unnamed medical doctor, so I just don't want to be remiss and let that go away.

THE COURT: So it's not going away, but here's what I will tell you. I'm going to hear from Director Daniels first. I think many of the evidentiary issues that have been raised can be addressed with Director Daniels' testimony as to whether or not these additional witnesses may or may not be necessary.

I do think, Mr. Anthony and Mr. Levenson, I would like for you when we come back from lunch to explain to me why I shouldn't dismiss Dr. Azzam from this case. That doesn't mean he wouldn't be available as a witness, but I have to tell you,

I'm not clear why he would remain as a defendant in this case. I'm just saying that so you all can be prepared to explain that to me when we come back.

With that, we will take our lunch break, and then we'll come back. I'd like for you all, it's 1 o'clock now, to be able to be back by 1:45, but we'll start at 2.

Mr. Gilmer, I'm sure you and Deputy Director Gittere can make sure that also Mr. Floyd has his lunch. I think he's already provided the lunch.

MR. GILMER: Provided at breakfast, Your Honor, so I presume he has it. We'll confirm.

THE COURT: Okay. Anything else then before we break? Mr. Levenson and Mr. Anthony?

MR. ANTHONY: Your Honor, I guess one thing we also wanted to keep track of was the discussion that we had about the provisions of Florida law. I think that we had discussed them. I don't remember if the context was about judicial notice or if it was regarding admission of exhibits. But I also wanted to make sure that we kept track of that as well, because we had several of those regulatory provisions and statutes that we believe governs the performance of a pharmacist under Florida law. And we have those as exhibits that we could refer to.

THE COURT: Well, they're Florida statutes. So here's what I will say to you. If you want to be able to make arguments to me based upon existing regulations and statutes, I

don't need to take judicial notice of that, you can simply argue them to me. And they can argue in response whether or not those are appropriate interpretations. But I don't need -- I don't need to take judicial notice of that. I'll allow you to argue that if you want to argue that about a particular witness and their relevant knowledge or bias. You can do that. Both sides can do that.

If it's public records or statutes, you don't need my permission to do that. So to the extent that you think that it's required, I certainly will allow. If you're asking for leave to make those arguments, I'll give you leave to make those arguments and for them to respond.

MR. ANTHONY: Thank you, Your Honor.

THE COURT: All right then. Thank you all. We'll be adjourned.

(Recessed at 12:59 p.m.)

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COURT REPORTER'S CERTIFICATE

I, PATRICIA L. GANCI, Official Court Reporter, United States District Court, District of Nevada, Las Vegas, Nevada, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

Date: December 16, 2021.

/s/ **Patricia L. Ganci**

Patricia L. Ganci, RMR, CRR

CCR #937